

AMENDED IN ASSEMBLY AUGUST 28, 2000

AMENDED IN ASSEMBLY AUGUST 25, 2000

AMENDED IN ASSEMBLY JUNE 15, 2000

AMENDED IN SENATE MAY 1, 2000

**SENATE BILL**

**No. 2094**

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**Introduced by Committee on Insurance (Senators Speier  
(Chair), Escutia, Figueroa, Hughes, Johnson, Johnston,  
Leslie, Lewis, Schiff, and Sher)**

February 25, 2000

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An act to amend Sections 56.05, 56.10, 56.30, and 56.101 of the Civil Code, to amend Sections 1347.15, 1363.5, 1364.5, 1367.01, 1367.51, 1368, 1368.04, 1370.4, 1375.4, 1386, and 1395.6 of, to amend and renumber Section 13933 of, and to repeal Section 1367.5 of, the Health and Safety Code, to amend Sections 10123.135 and 10145.3 of the Insurance Code, and to amend Section 25002 of the Welfare and Institutions Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 2094, as amended, Committee on Insurance. Health care.

Existing law provides for the regulation and licensing of health care service plans by the Department of Managed Care, effective no later than July 1, 2000, or earlier pursuant to an Executive order of the Governor. Existing law provides for the regulation and licensing of disability insurers by the Department of Insurance.

The Confidentiality of Medical Information Act limits the disclosure of medical information by a provider of health care, a health care service plan, or a contractor relative to a patient, as specified.

This bill would make technical changes to various provisions of that act and other health care-related provisions by correcting erroneous section references and making other related conforming and clarifying changes.

*This bill would incorporate additional changes to Section 56.10 of the Civil Code proposed by AB 2414 and SB 1903, to be operative if this bill and one or more of the other bills are enacted and become effective on or before January 1, 2001, and this bill is enacted last.*

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 56.05 of the Civil Code is  
2 amended to read:

3 56.05. For purposes of this part:

4 (a) "Authorization" means permission granted in  
5 accordance with Section 56.11 or 56.21 for the disclosure  
6 of medical information.

7 (b) "Authorized recipient" means any person who is  
8 authorized to receive medical information pursuant to  
9 Section 56.10 or 56.20.

10 (c) "Contractor" means any person or entity that is a  
11 medical group, independent practice association,  
12 pharmaceutical benefits manager, or a medical service  
13 organization and is not a health care service plan or  
14 provider of health care. "Contractor" shall not include  
15 insurance institutions as defined in subdivision (k) of  
16 Section 791.02 of the Insurance Code or pharmaceutical  
17 benefits managers licensed pursuant to the Knox-Keene  
18 Health Care Service Plan Act of 1975 (Chapter 2.2  
19 (commencing with Section 1340) of Division 2 of the  
20 Health and Safety Code).

21 (d) "Health care service plan" means any entity  
22 regulated pursuant to the Knox-Keene Health Care

1 Service Plan Act of 1975 (Chapter 2.2 (commencing with  
2 Section 1340) of Division 2 of the Health and Safety  
3 Code).

4 (e) “Licensed health care professional” means any  
5 person licensed or certified pursuant to Division 2  
6 (commencing with Section 500) of the Business and  
7 Professions Code, the Osteopathic Initiative Act or the  
8 Chiropractic Initiative Act, or Division 2.5 (commencing  
9 with Section 1797) of the Health and Safety Code.

10 (f) “Medical information” means any individually  
11 identifiable information, in electronic or physical form, in  
12 possession of or derived from a provider of health care,  
13 health care service plan, or contractor regarding a  
14 patient’s medical history, mental or physical condition, or  
15 treatment. “Individually identifiable” means that the  
16 medical information includes or contains any element of  
17 personal identifying information sufficient to allow  
18 identification of the individual, such as the patient’s  
19 name, address, electronic mail address, telephone  
20 number, or social security number, or other information  
21 that, alone or in combination with other publicly  
22 available information, reveals the individual’s identity.

23 (g) “Patient” means any natural person, whether or  
24 not still living, who received health care services from a  
25 provider of health care and to whom medical information  
26 pertains.

27 (h) “Provider of health care” means any person  
28 licensed or certified pursuant to Division 2 (commencing  
29 with Section 500) of the Business and Professions Code;  
30 any person licensed pursuant to the Osteopathic  
31 Initiative Act or the Chiropractic Initiative Act; any  
32 person certified pursuant to Division 2.5 (commencing  
33 with Section 1797) of the Health and Safety Code; any  
34 clinic, health dispensary, or health facility licensed  
35 pursuant to Division 2 (commencing with Section 1200)  
36 of the Health and Safety Code. “Provider of health care”  
37 shall not include insurance institutions as defined in  
38 subdivision (k) of Section 791.02 of the Insurance Code.

39 SEC. 2. Section 56.10 of the Civil Code is amended to  
40 read:



1 56.10. (a) No provider of health care, health care  
2 service plan, or contractor shall disclose medical  
3 information regarding a patient of the provider of health  
4 care or an enrollee or subscriber of a health care service  
5 plan without first obtaining an authorization, except as  
6 provided in subdivision (b) or (c).

7 (b) A provider of health care, a health care service  
8 plan, or a contractor shall disclose medical information if  
9 the disclosure is compelled by any of the following:

10 (1) By a court pursuant to an order of that court.

11 (2) By a board, commission, or administrative agency  
12 for purposes of adjudication pursuant to its lawful  
13 authority.

14 (3) By a party to a proceeding before a court or  
15 administrative agency pursuant to a subpoena, subpoena  
16 duces tecum, notice to appear served pursuant to Section  
17 1987 of the Code of Civil Procedure, or any provision  
18 authorizing discovery in a proceeding before a court or  
19 administrative agency.

20 (4) By a board, commission, or administrative agency  
21 pursuant to an investigative subpoena issued under  
22 Article 2 (commencing with Section 11180) of Chapter 2  
23 of Part 1 of Division 3 of Title 2 of the Government Code.

24 (5) By an arbitrator or arbitration panel, when  
25 arbitration is lawfully requested by either party, pursuant  
26 to a subpoena duces tecum issued under Section 1282.6 of  
27 the Code of Civil Procedure, or any other provision  
28 authorizing discovery in a proceeding before an  
29 arbitrator or arbitration panel.

30 (6) By a search warrant lawfully issued to a  
31 governmental law enforcement agency.

32 (7) By the patient or the patient's representative  
33 pursuant to Chapter 1 (commencing with Section  
34 123100) of Part 1 of Division 106 of the Health and Safety  
35 Code.

36 (8) When otherwise specifically required by law.

37 (c) A provider of health care, or a health care service  
38 plan may disclose medical information as follows:

39 (1) The information may be disclosed to providers of  
40 health care, health care service plans, contractors, or

1 other health care professionals or facilities for purposes of  
2 diagnosis or treatment of the patient. This includes, in an  
3 emergency situation, the communication of patient  
4 information by radio transmission or other means  
5 between emergency medical personnel at the scene of an  
6 emergency, or in an emergency medical transport  
7 vehicle, and emergency medical personnel at a health  
8 facility licensed pursuant to Chapter 2 (commencing  
9 with Section 1200) of Division 2 of the Health and Safety  
10 Code.

11 (2) The information may be disclosed to an insurer,  
12 employer, health care service plan, hospital service plan,  
13 employee benefit plan, governmental authority,  
14 contractor, or any other person or entity responsible for  
15 paying for health care services rendered to the patient,  
16 to the extent necessary to allow responsibility for  
17 payment to be determined and payment to be made. If  
18 (A) the patient is, by reason of a comatose or other  
19 disabling medical condition, unable to consent to the  
20 disclosure of medical information and (B) no other  
21 arrangements have been made to pay for the health care  
22 services being rendered to the patient, the information  
23 may be disclosed to a governmental authority to the  
24 extent necessary to determine the patient's eligibility for,  
25 and to obtain, payment under a governmental program  
26 for health care services provided to the patient. The  
27 information may also be disclosed to another provider of  
28 health care or health care service plan as necessary to  
29 assist the other provider or health care service plan in  
30 obtaining payment for health care services rendered by  
31 that provider of health care or health care service plan to  
32 the patient.

33 (3) The information may be disclosed to any person or  
34 entity that provides billing, claims management, medical  
35 data processing, or other administrative services for  
36 providers of health care or health care service plans or for  
37 any of the persons or entities specified in paragraph (2).  
38 However, no information so disclosed shall be further  
39 disclosed by the recipient in any way that would be  
40 violative of this part.

1 (4) The information may be disclosed to organized  
2 committees and agents of professional societies or of  
3 medical staffs of licensed hospitals, licensed health care  
4 service plans, professional standards review  
5 organizations, independent medical review  
6 organizations and their selected reviewers, utilization  
7 and quality control peer review organizations as  
8 established by Congress in Public Law 97-248 in 1982,  
9 contractors, or persons or organizations insuring,  
10 responsible for, or defending professional liability that a  
11 provider may incur, if the committees, agents, health care  
12 service plans, organizations, reviewers, contractors, or  
13 persons are engaged in reviewing the competence or  
14 qualifications of health care professionals or in reviewing  
15 health care services with respect to medical necessity,  
16 level of care, quality of care, or justification of charges.

17 (5) The information in the possession of any provider  
18 of health care or health care service plan may be  
19 reviewed by any private or public body responsible for  
20 licensing or accrediting the provider of health care or  
21 health care service plan. However, no patient identifying  
22 medical information may be removed from the premises  
23 except as expressly permitted or required elsewhere by  
24 law, nor shall that information be further disclosed by the  
25 recipient in any way that would violate this part.

26 (6) The information may be disclosed to the county  
27 coroner in the course of an investigation by the coroner's  
28 office.

29 (7) The information may be disclosed to public  
30 agencies, clinical investigators, including investigators  
31 conducting epidemiologic studies, health care research  
32 organizations, and accredited public or private nonprofit  
33 educational or health care institutions for bona fide  
34 research purposes. However, no information so disclosed  
35 shall be further disclosed by the recipient in any way that  
36 would disclose the identity of any patient or be violative  
37 of this part.

38 (8) A provider of health care or health care service  
39 plan that has created medical information as a result of  
40 employment-related health care services to an employee

1 conducted at the specific prior written request and  
2 expense of the employer may disclose to the employee's  
3 employer that part of the information that:

4 (A) Is relevant in a law suit, arbitration, grievance, or  
5 other claim or challenge to which the employer and the  
6 employee are parties and in which the patient has placed  
7 in issue his or her medical history, mental or physical  
8 condition, or treatment, provided that information may  
9 only be used or disclosed in connection with that  
10 proceeding.

11 (B) Describes functional limitations of the patient that  
12 may entitle the patient to leave from work for medical  
13 reasons or limit the patient's fitness to perform his or her  
14 present employment, provided that no statement of  
15 medical cause is included in the information disclosed.

16 (9) Unless the provider of health care or health care  
17 service plan is notified in writing of an agreement by the  
18 sponsor, insurer, or administrator to the contrary, the  
19 information may be disclosed to a sponsor, insurer, or  
20 administrator of a group or individual insured or  
21 uninsured plan or policy that the patient seeks coverage  
22 by or benefits from, if the information was created by the  
23 provider of health care or health care service plan as the  
24 result of services conducted at the specific prior written  
25 request and expense of the sponsor, insurer, or  
26 administrator for the purpose of evaluating the  
27 application for coverage or benefits.

28 (10) The information may be disclosed to a health care  
29 service plan by providers of health care that contract with  
30 the health care service plan and may be transferred  
31 among providers of health care that contract with the  
32 health care service plan, for the purpose of administering  
33 the health care service plan. Medical information may not  
34 otherwise be disclosed by a health care service plan  
35 except in accordance with the provisions of this part.

36 (11) Nothing in this part shall prevent the disclosure  
37 by a provider of health care or a health care service plan  
38 to an insurance institution, agent, or support  
39 organization, subject to Article 6.6 (commencing with  
40 Section 791) of Part 2 of Division 1 of the Insurance Code,

1 of medical information if the insurance institution, agent,  
2 or support organization has complied with all  
3 requirements for obtaining the information pursuant to  
4 Article 6.6 (commencing with Section 791) of Part 2 of  
5 Division 1 of the Insurance Code.

6 (12) The information relevant to the patient's  
7 condition and care and treatment provided may be  
8 disclosed to a probate court investigator engaged in  
9 determining the need for an initial conservatorship or  
10 continuation of an existent conservatorship, if the patient  
11 is unable to give informed consent, or to a probate court  
12 investigator, probation officer, or domestic relations  
13 investigator engaged in determining the need for an  
14 initial guardianship or continuation of an existent  
15 guardianship.

16 (13) The information may be disclosed to an organ  
17 procurement organization or a tissue bank processing the  
18 tissue of a decedent for transplantation into the body of  
19 another person, but only with respect to the donating  
20 decedent, for the purpose of aiding the transplant. For  
21 the purpose of this paragraph, the terms "tissue bank"  
22 and "tissue" have the same meaning as defined in Section  
23 1635 of the Health and Safety Code.

24 (14) The information may be disclosed when the  
25 disclosure is otherwise specifically authorized by law,  
26 such as the voluntary reporting, either directly or  
27 indirectly, to the federal Food and Drug Administration  
28 of adverse events related to drug products or medical  
29 device problems.

30 (15) Basic information including the patient's name,  
31 city of residence, age, sex, and general condition may be  
32 disclosed to a state or federally recognized disaster relief  
33 organization for the purpose of responding to disaster  
34 welfare inquiries.

35 (16) The information may be disclosed to a third party  
36 for purposes of encoding, encrypting, or otherwise  
37 anonymizing data. However, no information so disclosed  
38 shall be further disclosed by the recipient in any way that  
39 would be violative of this part, including the  
40 unauthorized manipulation of coded or encrypted





1 medical information that reveals individually identifiable  
2 medical information.

3 (17) For purposes of chronic disease management  
4 programs, information may be disclosed to any entity  
5 contracting with a health care service plan to monitor or  
6 administer care of enrollees for a covered benefit,  
7 provided that the disease management services and care  
8 are authorized by a treating physician.

9 (d) Except to the extent expressly authorized by the  
10 patient or enrollee or subscriber or as provided by  
11 subdivisions (b) and (c), no provider of health care,  
12 health care service plan, or contractor shall intentionally  
13 share, sell, or otherwise use any medical information for  
14 any purpose not necessary to provide health care services  
15 to the patient.

16 (e) Except to the extent expressly authorized by the  
17 patient or enrollee or subscriber or as provided by  
18 subdivisions (b) and (c), no contractor shall further  
19 disclose medical information regarding a patient of the  
20 provider of health care or an enrollee or subscriber of a  
21 health care service plan or insurer or self-insured  
22 employer received under this section to any person or  
23 entity that is not engaged in providing direct health care  
24 services to the patient or his or her provider of health care  
25 or health care service plan or insurer or self-insured  
26 employer.

27 *SEC. 2.1. Section 56.10 of the Civil Code is amended*  
28 *to read:*

29 56.10. (a) No provider of health care, ~~or~~ health care  
30 service plan, or contractor shall disclose medical  
31 information regarding a patient of the provider of health  
32 care or an enrollee or subscriber of a health care service  
33 plan without first obtaining an authorization, except as  
34 provided in subdivision (b) or (c).

35 (b) A provider of health care, a health care service  
36 plan, or a contractor shall disclose medical information if  
37 the disclosure is compelled by any of the following:

38 (1) By a court pursuant to an order of that court.

1 (2) By a board, commission, or administrative agency  
2 for purposes of adjudication pursuant to its lawful  
3 authority.

4 (3) By a party to a proceeding before a court or  
5 administrative agency pursuant to a subpoena, subpoena  
6 duces tecum, notice to appear served pursuant to Section  
7 1987 of the Code of Civil Procedure, or any provision  
8 authorizing discovery in a proceeding before a court or  
9 administrative agency.

10 (4) By a board, commission, or administrative agency  
11 pursuant to an investigative subpoena issued under  
12 Article 2 (commencing with Section 11180) of Chapter 2  
13 of Part 1 of Division 3 of Title 2 of the Government Code.

14 (5) By an arbitrator or arbitration panel, when  
15 arbitration is lawfully requested by either party, pursuant  
16 to a subpoena duces tecum issued under Section 1282.6 of  
17 the Code of Civil Procedure, or any other provision  
18 authorizing discovery in a proceeding before an  
19 arbitrator or arbitration panel.

20 (6) By a search warrant lawfully issued to a  
21 governmental law enforcement agency.

22 (7) By the patient or the patient's representative  
23 pursuant to Chapter 1 (commencing with Section  
24 123100) of Part 1 of Division 106 of the Health and Safety  
25 Code.

26 (8) When otherwise specifically required by law.

27 (c) A provider of health care, or a health care service  
28 plan may disclose medical information as follows:

29 (1) The information may be disclosed to providers of  
30 health care, health care service plans, *contractors*, or  
31 other health care professionals or facilities for purposes of  
32 diagnosis or treatment of the patient. This includes, in an  
33 emergency situation, the communication of patient  
34 information by radio transmission *or other means*  
35 between emergency medical personnel at the scene of an  
36 emergency, or in an emergency medical transport  
37 vehicle, and emergency medical personnel at a health  
38 facility licensed pursuant to Chapter 2 (commencing  
39 with Section ~~1200~~ 1250) of Division 2 of the Health and  
40 Safety Code.

1 (2) The information may be disclosed to an insurer,  
2 employer, health care service plan, hospital service plan,  
3 employee benefit plan, governmental authority,  
4 *contractor*, or any other person or entity responsible for  
5 paying for health care services rendered to the patient,  
6 to the extent necessary to allow responsibility for  
7 payment to be determined and payment to be made. If  
8 (A) the patient is, by reason of a comatose or other  
9 disabling medical condition, unable to consent to the  
10 disclosure of medical information and (B) no other  
11 arrangements have been made to pay for the health care  
12 services being rendered to the patient, the information  
13 may be disclosed to a governmental authority to the  
14 extent necessary to determine the patient's eligibility for,  
15 and to obtain, payment under a governmental program  
16 for health care services provided to the patient. The  
17 information may also be disclosed to another provider of  
18 health care or health care service plan as necessary to  
19 assist the other provider or health care service plan in  
20 obtaining payment for health care services rendered by  
21 that provider of health care or health care service plan to  
22 the patient.

23 (3) The information may be disclosed to any person or  
24 entity that provides billing, claims management, medical  
25 data processing, or other administrative services for  
26 providers of health care or health care service plans or for  
27 any of the persons or entities specified in paragraph (2).  
28 However, no information so disclosed shall be further  
29 disclosed by the recipient in any way that would be  
30 violative of this part.

31 (4) The information may be disclosed to organized  
32 committees and agents of professional societies or of  
33 medical staffs of licensed hospitals, licensed health care  
34 service plans, professional standards review  
35 organizations, *independent medical review*  
36 *organizations and their selected reviewers*, utilization  
37 and quality control peer review organizations as  
38 established by Congress in Public Law 97-248 in 1982,  
39 *contractors*, or persons or organizations insuring,  
40 responsible for, or defending professional liability that a

1 provider may incur, if the committees, agents, *health care*  
2 *service* plans, organizations, *reviewers*, *contractors*, or  
3 persons are engaged in reviewing the competence or  
4 qualifications of health care professionals or in reviewing  
5 health care services with respect to medical necessity,  
6 level of care, quality of care, or justification of charges.

7 (5) The information in the possession of any provider  
8 of health care or health care service plan may be  
9 reviewed by any private or public body responsible for  
10 licensing or accrediting the provider of health care or  
11 health care service plan. However, no patient identifying  
12 medical information may be removed from the premises  
13 except as expressly permitted or required elsewhere by  
14 law, *nor shall that information be further disclosed by the*  
15 *recipient in any way that would violate this part.*

16 (6) The information may be disclosed to the county  
17 coroner in the course of an investigation by the coroner's  
18 office.

19 (7) The information may be disclosed to public  
20 agencies, clinical investigators, including investigators  
21 conducting epidemiologic studies, health care research  
22 organizations, and accredited public or private nonprofit  
23 educational or health care institutions for bona fide  
24 research purposes. However, no information so disclosed  
25 shall be further disclosed by the recipient in any way that  
26 would disclose the identity of any patient or be violative  
27 of this part.

28 (8) A provider of health care or health care service  
29 plan that has created medical information as a result of  
30 employment-related health care services to an employee  
31 conducted at the specific prior written request and  
32 expense of the employer may disclose to the employee's  
33 employer that part of the information that:

34 (A) Is relevant in a law suit, arbitration, grievance, or  
35 other claim or challenge to which the employer and the  
36 employee are parties and in which the patient has placed  
37 in issue his or her medical history, mental or physical  
38 condition, or treatment, provided that information may  
39 only be used or disclosed in connection with that  
40 proceeding.

1 (B) Describes functional limitations of the patient that  
2 may entitle the patient to leave from work for medical  
3 reasons or limit the patient's fitness to perform his or her  
4 present employment, provided that no statement of  
5 medical cause is included in the information disclosed.

6 (9) Unless the provider of health care or health care  
7 service plan is notified in writing of an agreement by the  
8 sponsor, insurer, or administrator to the contrary, the  
9 information may be disclosed to a sponsor, insurer, or  
10 administrator of a group or individual insured or  
11 uninsured plan or policy that the patient seeks coverage  
12 by or benefits from, if the information was created by the  
13 provider of health care or health care service plan as the  
14 result of services conducted at the specific prior written  
15 request and expense of the sponsor, insurer, or  
16 administrator for the purpose of evaluating the  
17 application for coverage or benefits.

18 (10) The information may be disclosed to a health care  
19 service plan by providers of health care that contract with  
20 the health care service plan and may be transferred  
21 among providers of health care that contract with the  
22 health care service plan, for the purpose of administering  
23 the health care service plan. Medical information may not  
24 otherwise be disclosed by a health care service plan  
25 except in accordance with the provisions of this part.

26 (11) Nothing in this part shall prevent the disclosure  
27 by a provider of health care or a health care service plan  
28 to an insurance institution, agent, or support  
29 organization, subject to Article 6.6 (commencing with  
30 Section 791) of Part 2 of Division 1 of the Insurance Code,  
31 of medical information if the insurance institution, agent,  
32 or support organization has complied with all  
33 requirements for obtaining the information pursuant to  
34 Article 6.6 (commencing with Section 791) of Part 2 of  
35 Division 1 of the Insurance Code.

36 (12) The information relevant to the patient's  
37 condition and care and treatment provided may be  
38 disclosed to a probate court investigator engaged in  
39 determining the need for an initial conservatorship or  
40 continuation of an existent conservatorship, if the patient

1 is unable to give informed consent, or to a probate court  
2 investigator, probation officer, or domestic relations  
3 investigator engaged in determining the need for an  
4 initial guardianship or continuation of an existent  
5 guardianship.

6 (13) The information may be disclosed to an organ  
7 procurement organization or a tissue bank processing the  
8 tissue of a decedent for transplantation into the body of  
9 another person, but only with respect to the donating  
10 decedent, for the purpose of aiding the transplant. For  
11 the purpose of this paragraph, the terms “tissue bank”  
12 and “tissue” have the same meaning as defined in Section  
13 1635 of the Health and Safety Code.

14 (14) The information may be disclosed when the  
15 disclosure is otherwise specifically authorized by law,  
16 such as the voluntary reporting, either directly or  
17 indirectly, to the federal Food and Drug Administration  
18 of adverse events related to drug products or medical  
19 device problems.

20 (15) Basic information including the patient’s name,  
21 city of residence, age, sex, and general condition may be  
22 disclosed to a state or federally recognized disaster relief  
23 organization for the purpose of responding to disaster  
24 welfare inquiries.

25 (16) The information may be disclosed to a third party  
26 for purposes of encoding, encrypting, or otherwise  
27 anonymizing data. However, no information so disclosed  
28 shall be further disclosed by the recipient in any way that  
29 would be violative of this part, including the  
30 unauthorized manipulation of coded or encrypted  
31 medical information that reveals individually identifiable  
32 medical information.

33 (17) For purposes of ~~chronic~~ disease management  
34 programs *and services as defined in Section 1399.901 of*  
35 *the Health and Safety Code*, information may be  
36 disclosed *as follows*: (A) to any entity contracting with a  
37 health care service plan *or the health care service plan’s*  
38 *contractors* to monitor or administer care of enrollees for  
39 a covered benefit, provided that the disease management  
40 services and care are authorized by a treating physician,

1 or (B) to any disease management organization, as  
2 defined in Section 1399.900 of the Health and Safety Code,  
3 that complies fully with the physician authorization  
4 requirements of Section 1399.902 of the Health and Safety  
5 Code, provided that the health care service plan or its  
6 contractor provides or has provided a description of the  
7 disease management services to a treating physician or to  
8 the health care service plan's or contractor's network of  
9 physicians. Nothing in this paragraph shall be construed  
10 to require physician authorization for the care or  
11 treatment of the adherents of any well-recognized  
12 church or religious denomination who depend solely  
13 upon prayer or spiritual means for healing in the practice  
14 of the religion of that church or denomination.

15 (d) Except to the extent expressly authorized by the  
16 patient or enrollee or subscriber or as provided by  
17 subdivisions (b) and (c), no provider of health care,  
18 health care service plan, or contractor shall intentionally  
19 share, sell, or otherwise use any medical information for  
20 any purpose not necessary to provide health care services  
21 to the patient.

22 (e) Except to the extent expressly authorized by the  
23 patient or enrollee or subscriber or as provided by  
24 subdivisions (b) and (c), no contractor shall further  
25 disclose medical information regarding a patient of the  
26 provider of health care or an enrollee or subscriber of a  
27 health care service plan or insurer or self-insured  
28 employer received under this section to any person or  
29 entity that is not engaged in providing direct health care  
30 services to the patient or his or her provider of health care  
31 or health care service plan or insurer or self-insured  
32 employer.

33 SEC. 2.2. Section 56.10 of the Civil Code is amended  
34 to read:

35 56.10. (a) No provider of health care, ~~or~~ health care  
36 service plan, or contractor shall disclose medical  
37 information regarding a patient of the provider of health  
38 care or an enrollee or subscriber of a health care service  
39 plan without first obtaining an authorization, except as  
40 provided in subdivision (b) or (c).



(b) A provider of health care, a health care service plan, or a contractor shall disclose medical information if the disclosure is compelled by any of the following:

(1) By a court pursuant to an order of that court.

(2) By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.

(3) By a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to Section 1987 of the Code of Civil Procedure, or any provision authorizing discovery in a proceeding before a court or administrative agency.

(4) By a board, commission, or administrative agency pursuant to an investigative subpoena issued under Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

(5) By an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under Section 1282.6 of the Code of Civil Procedure, or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.

(6) By a search warrant lawfully issued to a governmental law enforcement agency.

(7) By the patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(8) When otherwise specifically required by law.

(c) A provider of health care, or a health care service plan may disclose medical information as follows:

(1) The information may be disclosed to providers of health care, health care service plans, *contractors*, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission *or other means* between emergency medical personnel at the scene of an emergency, or in an emergency medical transport



1 vehicle, and emergency medical personnel at a health  
2 facility licensed pursuant to Chapter 2 (commencing  
3 with Section 1200) of Division 2 of the Health and Safety  
4 Code.

5 (2) The information may be disclosed to an insurer,  
6 employer, health care service plan, hospital service plan,  
7 employee benefit plan, governmental authority,  
8 *contractor*, or any other person or entity responsible for  
9 paying for health care services rendered to the patient,  
10 to the extent necessary to allow responsibility for  
11 payment to be determined and payment to be made. If  
12 (A) the patient is, by reason of a comatose or other  
13 disabling medical condition, unable to consent to the  
14 disclosure of medical information and (B) no other  
15 arrangements have been made to pay for the health care  
16 services being rendered to the patient, the information  
17 may be disclosed to a governmental authority to the  
18 extent necessary to determine the patient's eligibility for,  
19 and to obtain, payment under a governmental program  
20 for health care services provided to the patient. The  
21 information may also be disclosed to another provider of  
22 health care or health care service plan as necessary to  
23 assist the other provider or health care service plan in  
24 obtaining payment for health care services rendered by  
25 that provider of health care or health care service plan to  
26 the patient.

27 (3) The information may be disclosed to any person or  
28 entity that provides billing, claims management, medical  
29 data processing, or other administrative services for  
30 providers of health care or health care service plans or for  
31 any of the persons or entities specified in paragraph (2).  
32 However, no information so disclosed shall be further  
33 disclosed by the recipient in any way that would be  
34 violative of this part.

35 (4) The information may be disclosed to organized  
36 committees and agents of professional societies or of  
37 medical staffs of licensed hospitals, licensed health care  
38 service plans, professional standards review  
39 organizations, *independent medical review*  
40 *organizations and their selected reviewers*, utilization

1 and quality control peer review organizations as  
2 established by Congress in Public Law 97-248 in 1982,  
3 *contractors*, or persons or organizations insuring,  
4 responsible for, or defending professional liability that a  
5 provider may incur, if the committees, agents, *health care*  
6 *service* plans, organizations, *reviewers*, *contractors*, or  
7 persons are engaged in reviewing the competence or  
8 qualifications of health care professionals or in reviewing  
9 health care services with respect to medical necessity,  
10 level of care, quality of care, or justification of charges.

11 (5) The information in the possession of any provider  
12 of health care or health care service plan may be  
13 reviewed by any private or public body responsible for  
14 licensing or accrediting the provider of health care or  
15 health care service plan. However, no patient identifying  
16 medical information may be removed from the premises  
17 except as expressly permitted or required elsewhere by  
18 law, *nor shall that information be further disclosed by the*  
19 *recipient in any way that would violate this part.*

20 (6) The information may be disclosed to the county  
21 coroner in the course of an investigation by the coroner's  
22 office.

23 (7) The information may be disclosed to public  
24 agencies, clinical investigators, including investigators  
25 conducting epidemiologic studies, health care research  
26 organizations, and accredited public or private nonprofit  
27 educational or health care institutions for bona fide  
28 research purposes. However, no information so disclosed  
29 shall be further disclosed by the recipient in any way that  
30 would disclose the identity of any patient or be violative  
31 of this part.

32 (8) A provider of health care or health care service  
33 plan that has created medical information as a result of  
34 employment-related health care services to an employee  
35 conducted at the specific prior written request and  
36 expense of the employer may disclose to the employee's  
37 employer that part of the information that:

38 (A) Is relevant in a law suit, arbitration, grievance, or  
39 other claim or challenge to which the employer and the  
40 employee are parties and in which the patient has placed

1 in issue his or her medical history, mental or physical  
2 condition, or treatment, provided that information may  
3 only be used or disclosed in connection with that  
4 proceeding.

5 (B) Describes functional limitations of the patient that  
6 may entitle the patient to leave from work for medical  
7 reasons or limit the patient's fitness to perform his or her  
8 present employment, provided that no statement of  
9 medical cause is included in the information disclosed.

10 (9) Unless the provider of health care or health care  
11 service plan is notified in writing of an agreement by the  
12 sponsor, insurer, or administrator to the contrary, the  
13 information may be disclosed to a sponsor, insurer, or  
14 administrator of a group or individual insured or  
15 uninsured plan or policy that the patient seeks coverage  
16 by or benefits from, if the information was created by the  
17 provider of health care or health care service plan as the  
18 result of services conducted at the specific prior written  
19 request and expense of the sponsor, insurer, or  
20 administrator for the purpose of evaluating the  
21 application for coverage or benefits.

22 (10) The information may be disclosed to a health care  
23 service plan by providers of health care that contract with  
24 the health care service plan and may be transferred  
25 among providers of health care that contract with the  
26 health care service plan, for the purpose of administering  
27 the health care service plan. Medical information may not  
28 otherwise be disclosed by a health care service plan  
29 except in accordance with the provisions of this part.

30 (11) Nothing in this part shall prevent the disclosure  
31 by a provider of health care or a health care service plan  
32 to an insurance institution, agent, or support  
33 organization, subject to Article 6.6 (commencing with  
34 Section 791) of Part 2 of Division 1 of the Insurance Code,  
35 of medical information if the insurance institution, agent,  
36 or support organization has complied with all  
37 requirements for obtaining the information pursuant to  
38 Article 6.6 (commencing with Section 791) of Part 2 of  
39 Division 1 of the Insurance Code.

1 (12) The information relevant to the patient's  
2 condition and care and treatment provided may be  
3 disclosed to a probate court investigator engaged in  
4 determining the need for an initial conservatorship or  
5 continuation of an existent conservatorship, if the patient  
6 is unable to give informed consent, or to a probate court  
7 investigator, probation officer, or domestic relations  
8 investigator engaged in determining the need for an  
9 initial guardianship or continuation of an existent  
10 guardianship.

11 (13) The information may be disclosed to an organ  
12 procurement organization or a tissue bank processing the  
13 tissue of a decedent for transplantation into the body of  
14 another person, but only with respect to the donating  
15 decedent, for the purpose of aiding the transplant. For  
16 the purpose of this paragraph, the terms "tissue bank"  
17 and "tissue" have the same meaning as defined in Section  
18 1635 of the Health and Safety Code.

19 (14) The information may be disclosed when the  
20 disclosure is otherwise specifically authorized by law,  
21 such as the voluntary reporting, either directly or  
22 indirectly, to the federal Food and Drug Administration  
23 of adverse events related to drug products or medical  
24 device problems.

25 (15) Basic information including the patient's name,  
26 city of residence, age, sex, and general condition may be  
27 disclosed to a state or federally recognized disaster relief  
28 organization for the purpose of responding to disaster  
29 welfare inquiries.

30 (16) The information may be disclosed to a third party  
31 for purposes of encoding, encrypting, or otherwise  
32 anonymizing data. However, no information so disclosed  
33 shall be further disclosed by the recipient in any way that  
34 would be violative of this part, including the  
35 unauthorized manipulation of coded or encrypted  
36 medical information that reveals individually identifiable  
37 medical information.

38 (17) For purposes of chronic disease management  
39 programs, information may be disclosed to any entity  
40 contracting with a health care service plan to monitor or

1 administer care of enrollees for a covered benefit,  
2 provided that the disease management services and care  
3 are authorized by a treating physician.

4 (d) Except to the extent expressly authorized by the  
5 patient or enrollee or subscriber or as provided by  
6 subdivisions (b) and (c), no provider of health care,  
7 health care service ~~plan, or contractor~~ *plan contractor, or*  
8 *corporation and its subsidiaries and affiliates* shall  
9 intentionally share, sell, or otherwise use any medical  
10 information for any purpose not necessary to provide  
11 health care services to the patient.

12 (e) Except to the extent expressly authorized by the  
13 patient or enrollee or subscriber or as provided by  
14 subdivisions (b) and (c), no contractor *or corporation*  
15 *and its subsidiaries and affiliates* shall further disclose  
16 medical information regarding a patient of the provider  
17 of health care or an enrollee or subscriber of a health care  
18 service plan or insurer or self-insured employer received  
19 under this section to any person or entity that is not  
20 engaged in providing direct health care services to the  
21 patient or his or her provider of health care or health care  
22 service plan or insurer or self-insured employer.

23 *SEC. 2.3. Section 56.10 of the Civil Code is amended*  
24 *to read:*

25 56.10. (a) No provider of health care, ~~or~~ health care  
26 service plan, or contractor shall disclose medical  
27 information regarding a patient of the provider of health  
28 care or an enrollee or subscriber of a health care service  
29 plan without first obtaining an authorization, except as  
30 provided in subdivision (b) or (c).

31 (b) A provider of health care, a health care service  
32 plan, or a contractor shall disclose medical information if  
33 the disclosure is compelled by any of the following:

34 (1) By a court pursuant to an order of that court.

35 (2) By a board, commission, or administrative agency  
36 for purposes of adjudication pursuant to its lawful  
37 authority.

38 (3) By a party to a proceeding before a court or  
39 administrative agency pursuant to a subpoena, subpoena  
40 duces tecum, notice to appear served pursuant to Section

1 1987 of the Code of Civil Procedure, or any provision  
2 authorizing discovery in a proceeding before a court or  
3 administrative agency.

4 (4) By a board, commission, or administrative agency  
5 pursuant to an investigative subpoena issued under  
6 Article 2 (commencing with Section 11180) of Chapter 2  
7 of Part 1 of Division 3 of Title 2 of the Government Code.

8 (5) By an arbitrator or arbitration panel, when  
9 arbitration is lawfully requested by either party, pursuant  
10 to a subpoena duces tecum issued under Section 1282.6 of  
11 the Code of Civil Procedure, or any other provision  
12 authorizing discovery in a proceeding before an  
13 arbitrator or arbitration panel.

14 (6) By a search warrant lawfully issued to a  
15 governmental law enforcement agency.

16 (7) By the patient or the patient's representative  
17 pursuant to Chapter 1 (commencing with Section  
18 123100) of Part 1 of Division 106 of the Health and Safety  
19 Code.

20 (8) When otherwise specifically required by law.

21 (c) A provider of health care, or a health care service  
22 plan may disclose medical information as follows:

23 (1) The information may be disclosed to providers of  
24 health care, health care service plans, *contractor's* or  
25 other health care professionals or facilities for purposes of  
26 diagnosis or treatment of the patient. This includes, in an  
27 emergency situation, the communication of patient  
28 information by radio transmission *or other means*  
29 between emergency medical personnel at the scene of an  
30 emergency, or in an emergency medical transport  
31 vehicle, and emergency medical personnel at a health  
32 facility licensed pursuant to Chapter 2 (commencing  
33 with Section ~~1200~~ 1250) of Division 2 of the Health and  
34 Safety Code.

35 (2) The information may be disclosed to an insurer,  
36 employer, health care service plan, hospital service plan,  
37 employee benefit plan, governmental authority,  
38 *contractor* or any other person or entity responsible for  
39 paying for health care services rendered to the patient,  
40 to the extent necessary to allow responsibility for

1 payment to be determined and payment to be made. If  
 2 (A) the patient is, by reason of a comatose or other  
 3 disabling medical condition, unable to consent to the  
 4 disclosure of medical information and (B) no other  
 5 arrangements have been made to pay for the health care  
 6 services being rendered to the patient, the information  
 7 may be disclosed to a governmental authority to the  
 8 extent necessary to determine the patient's eligibility for,  
 9 and to obtain, payment under a governmental program  
 10 for health care services provided to the patient. The  
 11 information may also be disclosed to another provider of  
 12 health care or health care service plan as necessary to  
 13 assist the other provider or health care service plan in  
 14 obtaining payment for health care services rendered by  
 15 that provider of health care or health care service plan to  
 16 the patient.

17 (3) The information may be disclosed to any person or  
 18 entity that provides billing, claims management, medical  
 19 data processing, or other administrative services for  
 20 providers of health care or health care service plans or for  
 21 any of the persons or entities specified in paragraph (2).  
 22 However, no information so disclosed shall be further  
 23 disclosed by the recipient in any way that would be  
 24 violative of this part.

25 (4) The information may be disclosed to organized  
 26 committees and agents of professional societies or of  
 27 medical staffs of licensed hospitals, licensed health care  
 28 service plans, professional standards review  
 29 organizations, *independent medical review*  
 30 *organizations and their selected reviewers* utilization and  
 31 quality control peer review organizations as established  
 32 by Congress in Public Law 97-248 in 1982, *contractors* or  
 33 persons or organizations insuring, responsible for, or  
 34 defending professional liability that a provider may incur,  
 35 if the committees, agents, *health care service* plans,  
 36 organizations, *reviewers, contractors* or persons are  
 37 engaged in reviewing the competence or qualifications of  
 38 health care professionals or in reviewing health care  
 39 services with respect to medical necessity, level of care,  
 40 quality of care, or justification of charges.



1 (5) The information in the possession of any provider  
2 of health care or health care service plan may be  
3 reviewed by any private or public body responsible for  
4 licensing or accrediting the provider of health care or  
5 health care service plan. However, no patient identifying  
6 medical information may be removed from the premises  
7 except as expressly permitted or required elsewhere by  
8 law, *nor shall that information be further disclosed by the*  
9 *recipient in any way that would violate this part.*

10 (6) The information may be disclosed to the county  
11 coroner in the course of an investigation by the coroner's  
12 office.

13 (7) The information may be disclosed to public  
14 agencies, clinical investigators, including investigators  
15 conducting epidemiologic studies, health care research  
16 organizations, and accredited public or private nonprofit  
17 educational or health care institutions for bona fide  
18 research purposes. However, no information so disclosed  
19 shall be further disclosed by the recipient in any way that  
20 would disclose the identity of any patient or be violative  
21 of this part.

22 (8) A provider of health care or health care service  
23 plan that has created medical information as a result of  
24 employment-related health care services to an employee  
25 conducted at the specific prior written request and  
26 expense of the employer may disclose to the employee's  
27 employer that part of the information that:

28 (A) Is relevant in a law suit, arbitration, grievance, or  
29 other claim or challenge to which the employer and the  
30 employee are parties and in which the patient has placed  
31 in issue his or her medical history, mental or physical  
32 condition, or treatment, provided that information may  
33 only be used or disclosed in connection with that  
34 proceeding.

35 (B) Describes functional limitations of the patient that  
36 may entitle the patient to leave from work for medical  
37 reasons or limit the patient's fitness to perform his or her  
38 present employment, provided that no statement of  
39 medical cause is included in the information disclosed.





1 (9) Unless the provider of health care or health care  
2 service plan is notified in writing of an agreement by the  
3 sponsor, insurer, or administrator to the contrary, the  
4 information may be disclosed to a sponsor, insurer, or  
5 administrator of a group or individual insured or  
6 uninsured plan or policy that the patient seeks coverage  
7 by or benefits from, if the information was created by the  
8 provider of health care or health care service plan as the  
9 result of services conducted at the specific prior written  
10 request and expense of the sponsor, insurer, or  
11 administrator for the purpose of evaluating the  
12 application for coverage or benefits.

13 (10) The information may be disclosed to a health care  
14 service plan by providers of health care that contract with  
15 the health care service plan and may be transferred  
16 among providers of health care that contract with the  
17 health care service plan, for the purpose of administering  
18 the health care service plan. Medical information may not  
19 otherwise be disclosed by a health care service plan  
20 except in accordance with the provisions of this part.

21 (11) Nothing in this part shall prevent the disclosure  
22 by a provider of health care or a health care service plan  
23 to an insurance institution, agent, or support  
24 organization, subject to Article 6.6 (commencing with  
25 Section 791) of Part 2 of Division 1 of the Insurance Code,  
26 of medical information if the insurance institution, agent,  
27 or support organization has complied with all  
28 requirements for obtaining the information pursuant to  
29 Article 6.6 (commencing with Section 791) of Part 2 of  
30 Division 1 of the Insurance Code.

31 (12) The information relevant to the patient's  
32 condition and care and treatment provided may be  
33 disclosed to a probate court investigator engaged in  
34 determining the need for an initial conservatorship or  
35 continuation of an existent conservatorship, if the patient  
36 is unable to give informed consent, or to a probate court  
37 investigator, probation officer, or domestic relations  
38 investigator engaged in determining the need for an  
39 initial guardianship or continuation of an existent  
40 guardianship.

1 (13) The information may be disclosed to an organ  
2 procurement organization or a tissue bank processing the  
3 tissue of a decedent for transplantation into the body of  
4 another person, but only with respect to the donating  
5 decedent, for the purpose of aiding the transplant. For  
6 the purpose of this paragraph, the terms “tissue bank”  
7 and “tissue” have the same meaning as defined in Section  
8 1635 of the Health and Safety Code.

9 (14) The information may be disclosed when the  
10 disclosure is otherwise specifically authorized by law,  
11 such as the voluntary reporting, either directly or  
12 indirectly, to the federal Food and Drug Administration  
13 of adverse events related to drug products or medical  
14 device problems.

15 (15) Basic information including the patient’s name,  
16 city of residence, age, sex, and general condition may be  
17 disclosed to a state or federally recognized disaster relief  
18 organization for the purpose of responding to disaster  
19 welfare inquiries.

20 (16) The information may be disclosed to a third party  
21 for purposes of encoding, encrypting, or otherwise  
22 anonymizing data. However, no information so disclosed  
23 shall be further disclosed by the recipient in any way that  
24 would be violative of this part, including the  
25 unauthorized manipulation of coded or encrypted  
26 medical information that reveals individually identifiable  
27 medical information.

28 (17) For purposes of ~~chronic~~ disease management  
29 programs *and services as defined in Section 1399.901 of*  
30 *the Health and Safety Code*, information may be  
31 disclosed *as follows: (A) to any entity contracting with a*  
32 *health care service plan or the health care service plan’s*  
33 *contractors to monitor or administer care of enrollees for*  
34 *a covered benefit, provided that the disease management*  
35 *services and care are authorized by a treating physician,*  
36 *or (B) to any disease management organization, as*  
37 *defined in Section 1399.900 of the Health and Safety Code,*  
38 *that complies fully with the physician authorization*  
39 *requirements of Section 1399.902 of the Health and Safety*  
40 *Code, provided that the health care service plan or its*

1 *contractor provides or has provided a description of the*  
2 *disease management services to a treating physician or to*  
3 *the health care service plan's or contractor's network of*  
4 *physicians. Nothing in this paragraph shall be construed*  
5 *to require physician authorization for the care or*  
6 *treatment of the adherents of any well-recognized*  
7 *church or religious denomination who depend solely*  
8 *upon prayer or spiritual means for healing in the practice*  
9 *of the religion of that church or denomination.*

10 (d) Except to the extent expressly authorized by the  
11 patient or enrollee or subscriber or as provided by  
12 subdivisions (b) and (c), no provider of health care,  
13 health care service ~~plan, or contractor~~ *plan contractor, or*  
14 *corporation and its subsidiaries and affiliates* shall  
15 intentionally share, sell, or otherwise use any medical  
16 information for any purpose not necessary to provide  
17 health care services to the patient.

18 (e) Except to the extent expressly authorized by the  
19 patient or enrollee or subscriber or as provided by  
20 subdivisions (b) and (c), no contractor *or corporation*  
21 *and its subsidiaries and affiliates* shall further disclose  
22 medical information regarding a patient of the provider  
23 of health care or an enrollee or subscriber of a health care  
24 service plan or insurer or self-insured employer received  
25 under this section to any person or entity that is not  
26 engaged in providing direct health care services to the  
27 patient or his or her provider of health care or health care  
28 service plan or insurer or self-insured employer.

29 SEC. 3. Section 56.30 of the Civil Code is amended to  
30 read:

31 56.30. The disclosure and use of the following medical  
32 information shall not be subject to the limitations of this  
33 part:

34 (a) (Mental health and developmental disabilities)  
35 Information and records obtained in the course of  
36 providing services under Division 4 (commencing with  
37 Section 4000), Division 4.1 (commencing with Section  
38 4400), Division 4.5 (commencing with Section 4500),  
39 Division 5 (commencing with Section 5000), Division 6  
40 (commencing with Section 6000), or Division 7

1 (commencing with Section 7100) of the Welfare and  
2 Institutions Code.

3 (b) (Public social services) Information and records  
4 that are subject to Sections 10850, 14124.1, and 14124.2 of  
5 the Welfare and Institutions Code.

6 (c) (State health services, communicable diseases,  
7 developmental disabilities) Information and records  
8 maintained pursuant to former Chapter 2 (commencing  
9 with Section 200) of Part 1 of Division 1 of the Health and  
10 Safety Code and pursuant to the Communicable Disease  
11 Prevention and Control Act (subdivision (a) of Section 27  
12 of the Health and Safety Code).

13 (d) (Licensing and statistics) Information and records  
14 maintained pursuant to Division 2 (commencing with  
15 Section 1200) and Part 1 (commencing with Section  
16 102100) of Division 102 of the Health and Safety Code;  
17 pursuant to Chapter 3 (commencing with Section 1200)  
18 of Division 2 of the Business and Professions Code; and  
19 pursuant to Section 8608, 8817, or 8909 of the Family  
20 Code.

21 (e) (Medical survey, workers' safety) Information and  
22 records acquired and maintained or disclosed pursuant to  
23 Sections 1380 and 1382 of the Health and Safety Code and  
24 pursuant to Division 5 (commencing with Section 6300)  
25 of the Labor Code.

26 (f) (Industrial accidents) Information and records  
27 acquired, maintained, or disclosed pursuant to Division 1  
28 (commencing with Section 50), Division 4 (commencing  
29 with Section 3200), Division 4.5 (commencing with  
30 Section 6100), and Division 4.7 (commencing with  
31 Section 6200) of the Labor Code.

32 (g) (Law enforcement) Information and records  
33 maintained by a health facility which are sought by a law  
34 enforcement agency under Chapter 3.5 (commencing  
35 with Section 1543) of Title 12 of Part 2 of the Penal Code.

36 (h) (Investigations of employment accident or illness)  
37 Information and records sought as part of an investigation  
38 of an on-the-job accident or illness pursuant to Division 5  
39 (commencing with Section 6300) of the Labor Code or  
40 pursuant to Section 105200 of the Health and Safety Code.



1 (i) (Alcohol or drug abuse) Information and records  
2 subject to the federal alcohol and drug abuse regulations  
3 (Part 2 (commencing with Section 2.1) of subchapter A  
4 of Chapter 1 of Title 42 of the Code of Federal  
5 Regulations) or to Section 11977 of the Health and Safety  
6 Code dealing with narcotic and drug abuse.

7 (j) (Patient discharge data) Nothing in this part shall  
8 be construed to limit, expand, or otherwise affect the  
9 authority of the California Health Facilities Commission  
10 to collect patient discharge information from health  
11 facilities.

12 (k) Medical information and records disclosed to, and  
13 their use by, the Insurance Commissioner, the Director  
14 of the Department of Managed Health Care, the Division  
15 of Industrial Accidents, the Workers' Compensation  
16 Appeals Board, the Department of Insurance, or the  
17 Department of Managed Health Care.

18 Sec. 4. Section 56.101 of the Civil Code is amended to  
19 read:

20 56.101. Every provider of health care, health care  
21 service plan, or contractor who creates, maintains,  
22 preserves, stores, abandons, destroys, or disposes of  
23 medical records shall do so in a manner that preserves the  
24 confidentiality of the information contained therein. Any  
25 provider of health care, health care service plan, or  
26 contractor who negligently creates, maintains, preserves,  
27 stores, abandons, destroys, or disposes of medical records  
28 shall be subject to the remedies and penalties provided  
29 under subdivisions (b) and (c) of Section 56.36.

30 SEC. 5. Section 1347.15 of the Health and Safety Code  
31 is amended to read:

32 1347.15. (a) There is hereby established in the  
33 Department of Managed Health Care the Financial  
34 Solvency Standards Board composed of eight members.  
35 The members shall consist of the director, or the  
36 director's designee, and seven members appointed by the  
37 director. The seven members appointed by the director  
38 may be, but are not necessarily limited to, individuals  
39 with training and experience in the following subject  
40 areas or fields: medical and health care economics;

1 accountancy, with experience in integrated or affiliated  
2 health care delivery systems; excess loss insurance  
3 underwriting in the medical, hospital, and health plan  
4 business; actuarial studies in the area of health care  
5 delivery systems; management and administration in  
6 integrated or affiliated health care delivery systems;  
7 investment banking; and information technology in  
8 integrated or affiliated health care delivery systems. The  
9 members appointed by the director shall be appointed for  
10 a term of three years, but may be removed or reappointed  
11 by the director before the expiration of the term.

12 (b) The purpose of the board is to do all of the  
13 following:

14 (1) Advise the director on matters of financial  
15 solvency affecting the delivery of health care services.

16 (2) Develop and recommend to the director financial  
17 solvency requirements and standards relating to plan  
18 operations, plan-affiliate operations and transactions,  
19 plan-provider contractual relationships, and  
20 provider-affiliate operations and transactions.

21 (3) Periodically monitor and report on the  
22 implementation and results of the financial solvency  
23 requirements and standards.

24 (c) Financial solvency requirements and standards  
25 recommended to the director by the board may, after a  
26 period of review and comment not to exceed 45 days and,  
27 notwithstanding Section 1347, be noticed for adoption as  
28 regulations as proposed or modified under the  
29 rulemaking provisions of the Administrative Procedure  
30 Act (Chapter 3.5 (commencing with Section 11340) of  
31 Part 1 of Division 3 of Title 2 of the Government Code).  
32 During the director's 45-day review and comment  
33 period, the director, in consultation with the board, may  
34 postpone the adoption of the requirements and standards  
35 pending further review and comment. Within five  
36 business days of receipt by the director of the  
37 recommendation of the board, the director shall send an  
38 information only copy of the recommendations to the  
39 members of the Advisory Committee on Managed Care.  
40 Nothing in this subdivision prohibits the director from

1 adopting regulations, including emergency regulations,  
2 under the rulemaking provisions of the Administrative  
3 Procedure Act.

4 (d) Except as provided in subdivision (e), the board  
5 shall meet at least quarterly and at the call of the chair.  
6 In order to preserve the independence of the board, the  
7 director shall not serve as chair. The members of the  
8 board may establish their own rules and procedures. All  
9 members shall serve without compensation, but shall be  
10 reimbursed from department funds for expenses actually  
11 and necessarily incurred in the performance of their  
12 duties.

13 (e) During the two years from the date of the first  
14 meeting of the board, the board shall meet monthly in  
15 order to expeditiously fulfill its purpose under paragraphs  
16 (1) and (2) of subdivision (b).

17 (f) For purposes of this section, “board” means the  
18 Financial Solvency Standards Board.

19 SEC. 6. Section 1363.5 of the Health and Safety Code  
20 is amended to read:

21 1363.5. (a) A plan shall disclose or provide for the  
22 disclosure to the director and to network providers the  
23 process the plan, its contracting provider groups, or any  
24 entity with which the plan contracts for services that  
25 include utilization review or utilization management  
26 functions, uses to authorize, modify, or deny health care  
27 services under the benefits provided by the plan,  
28 including coverage for subacute care, transitional  
29 inpatient care, or care provided in skilled nursing  
30 facilities. A plan shall also disclose those processes to  
31 enrollees or persons designated by an enrollee, or to any  
32 other person or organization, upon request. The  
33 disclosure to the director shall include the policies,  
34 procedures, and the description of the process that are  
35 filed with the director pursuant to subdivision (b) of  
36 Section 1367.01.

37 (b) The criteria or guidelines used by plans, or any  
38 entities with which plans contract for services that  
39 include utilization review or utilization management



1 functions, to determine whether to authorize, modify, or  
2 deny health care services shall:

3 (1) Be developed with involvement from actively  
4 practicing health care providers.

5 (2) Be consistent with sound clinical principles and  
6 processes.

7 (3) Be evaluated, and updated if necessary, at least  
8 annually.

9 (4) If used as the basis of a decision to modify, delay,  
10 or deny services in a specified case under review, be  
11 disclosed to the provider and the enrollee in that  
12 specified case.

13 (5) Be available to the public upon request. A plan  
14 shall only be required to disclose the criteria or guidelines  
15 for the specific procedures or conditions requested. A  
16 plan may charge reasonable fees to cover administrative  
17 expenses related to disclosing criteria or guidelines  
18 pursuant to this paragraph, limited to copying and  
19 postage costs. The plan may also make the criteria or  
20 guidelines available through electronic communication  
21 means.

22 (c) The disclosure required by paragraph (5) of  
23 subdivision (b) shall be accompanied by the following  
24 notice: “The materials provided to you are guidelines  
25 used by this plan to authorize, modify, or deny care for  
26 persons with similar illnesses or conditions. Specific care  
27 and treatment may vary depending on individual need  
28 and the benefits covered under your contract.”

29 SEC. 7. Section 1364.5 of the Health and Safety Code  
30 is amended to read:

31 1364.5. (a) On or before July 1, 2001, every health  
32 care service plan shall file with the director a copy of their  
33 policies and procedures to protect the security of patient  
34 medical information to ensure compliance with the  
35 Confidentiality of Information Act (Part 2.6  
36 commencing with Section 56) of Division 1 of the Civil  
37 Code). Any amendment to the policies and procedures  
38 shall be filed in accordance with Section 1352.

39 (b) On and after July 1, 2001, every health care service  
40 plan shall, upon request, provide to enrollees and



1 subscribers a written statement that describes how the  
2 contracting organization or health care service plan  
3 maintains the confidentiality of medical information  
4 obtained by and in the possession of the contracting  
5 organization or the health care service plan.

6 (c) The statement required by subdivision (b) shall be  
7 in at least 12-point type and meet the following  
8 requirements:

9 (1) The statement shall describe how the contracting  
10 organization or health care service plan protects the  
11 confidentiality of medical information pursuant to this  
12 article and inform patients or enrollees and subscribers  
13 that any disclosure of medical information beyond the  
14 provisions of the law is prohibited.

15 (2) The statement shall describe the types of medical  
16 information that may be collected and the type of sources  
17 that may be used to collect the information, the purposes  
18 for which the contracting organization or plan will obtain  
19 medical information from other health care providers.

20 (3) The statement shall describe the circumstances  
21 under which medical information may be disclosed  
22 without prior authorization, pursuant to Section 56.10 of  
23 the Civil Code.

24 (4) The statement shall describe how patients or  
25 enrollees and subscribers may obtain access to medical  
26 information created by and in the possession of the  
27 contracting organization or health care service plan,  
28 including copies of medical information.

29 (d) On and after July 1, 2001, every health care service  
30 plan shall include in its evidence of coverage or disclosure  
31 form the following notice, in 12-point type:

32  
33 A STATEMENT DESCRIBING (NAME OR PLAN  
34 OR "OUR") POLICIES AND PROCEDURES FOR  
35 PRESERVING THE CONFIDENTIALITY OF  
36 MEDICAL RECORDS IS AVAILABLE AND WILL  
37 BE FURNISHED TO YOU UPON REQUEST.

38  
39 SEC. 8. Section 1367.01 of the Health and Safety Code  
40 is amended to read:

1 1367.01. (a) Every health care service plan and any  
2 entity with which it contracts for services that include  
3 utilization review or utilization management functions,  
4 that prospectively, retrospectively, or concurrently  
5 reviews and approves, modifies, delays, or denies, based  
6 in whole or in part on medical necessity, requests by  
7 providers prior to, retrospectively, or concurrent with  
8 the provision of health care services to enrollees, or that  
9 delegates these functions to medical groups or  
10 independent practice associations or to other contracting  
11 providers, shall comply with this section.

12 (b) A health care service plan that is subject to this  
13 section shall have written policies and procedures  
14 establishing the process by which the plan prospectively,  
15 retrospectively, or concurrently reviews and approves,  
16 modifies, delays, or denies, based in whole or in part on  
17 medical necessity, requests by providers of health care  
18 services for plan enrollees. These policies and procedures  
19 shall ensure that decisions based on the medical necessity  
20 of proposed health care services are consistent with  
21 criteria or guidelines that are supported by clinical  
22 principles and processes. These criteria and guidelines  
23 shall be developed pursuant to Section 1363.5. These  
24 policies and procedures, and a description of the process  
25 by which the plan reviews and approves, modifies, delays,  
26 or denies requests by providers prior to, retrospectively,  
27 or concurrent with the provision of health care services  
28 to enrollees, shall be filed with the director for review and  
29 approval, and shall be disclosed by the plan to providers  
30 and enrollees upon request, and by the plan to the public  
31 upon request.

32 (c) Every health care service plan subject to this  
33 section shall employ or designate a medical director who  
34 holds an unrestricted license to practice medicine in this  
35 state issued pursuant to Section 2050 of the Business and  
36 Professions Code or pursuant to the Osteopathic Act, or,  
37 if the plan is a specialized health care service plan, a  
38 clinical director with California licensure in a clinical area  
39 appropriate to the type of care provided by the  
40 specialized health care service plan. The medical director

1 or clinical director shall ensure that the process by which  
2 the plan reviews and approves, modifies, or denies, based  
3 in whole or in part on medical necessity, requests by  
4 providers prior to, retrospectively, or concurrent with  
5 the provision of health care services to enrollees, complies  
6 with the requirements of this section.

7 (d) If health plan personnel, or individuals under  
8 contract to the plan to review requests by providers,  
9 approve the provider's request, pursuant to subdivision  
10 (b), the decision shall be communicated to the provider  
11 pursuant to subdivision (h).

12 (e) No individual, other than a licensed physician or a  
13 licensed health care professional who is competent to  
14 evaluate the specific clinical issues involved in the health  
15 care services requested by the provider, may deny or  
16 modify requests for authorization of health care services  
17 for an enrollee for reasons of medical necessity. The  
18 decision of the physician or other health care professional  
19 shall be communicated to the provider and the enrollee  
20 pursuant to subdivision (h).

21 (f) The criteria or guidelines used by the health care  
22 service plan to determine whether to approve, modify, or  
23 deny requests by providers prior to, retrospectively, or  
24 concurrent with, the provision of health care services to  
25 enrollees shall be consistent with clinical principles and  
26 processes. These criteria and guidelines shall be  
27 developed pursuant to the requirements of Section  
28 1363.5.

29 (g) If the health care service plan requests medical  
30 information from providers in order to determine  
31 whether to approve, modify, or deny requests for  
32 authorization, the plan shall request only the information  
33 reasonably necessary to make the determination.

34 (h) In determining whether to approve, modify, or  
35 deny requests by providers prior to, retrospectively, or  
36 concurrent with the provision of health care services to  
37 enrollees, based in whole or in part on medical necessity,  
38 every health care service plan subject to this section shall  
39 meet the following requirements:

1 (1) Decisions to approve, modify, or deny, based on  
2 medical necessity, requests by providers prior to, or  
3 concurrent with the provision of health care services to  
4 enrollees that do not meet the requirements for the  
5 72-hour review required by paragraph (2), shall be made  
6 in a timely fashion appropriate for the nature of the  
7 enrollee's condition, not to exceed five business days from  
8 the plan's receipt of the information reasonably necessary  
9 and requested by the plan to make the determination. In  
10 cases where the review is retrospective, the decision shall  
11 be communicated to the individual who received  
12 services, or to the individual's designee, within 30 days of  
13 the receipt of information that is reasonably necessary to  
14 make this determination, and shall be communicated to  
15 the provider in a manner that is consistent with current  
16 law. For purposes of this section, retrospective reviews  
17 shall be for care rendered on or after January 1, 2000.

18 (2) When the enrollee's condition is such that the  
19 enrollee faces an imminent and serious threat to his or her  
20 health including, but not limited to, the potential loss of  
21 life, limb, or other major bodily function, or the normal  
22 timeframe for the decisionmaking process, as described  
23 in paragraph (1), would be detrimental to the enrollee's  
24 life or health or could jeopardize the enrollee's ability to  
25 regain maximum function, decisions to approve, modify,  
26 or deny requests by providers prior to, or concurrent  
27 with, the provision of health care services to enrollees,  
28 shall be made in a timely fashion appropriate for the  
29 nature of the enrollee's condition, not to exceed 72 hours  
30 after the plan's receipt of the information reasonably  
31 necessary and requested by the plan to make the  
32 determination. Nothing in this section shall be construed  
33 to alter the requirements of subdivision (b) of Section  
34 1371.4. Notwithstanding Section 1371.4, the requirements  
35 of this division shall be applicable to all health plans and  
36 other entities conducting utilization review or utilization  
37 management.

38 (3) Decisions to approve, modify, or deny requests by  
39 providers for authorization prior to, or concurrent with,  
40 the provision of health care services to enrollees shall be

1 communicated to the requesting provider within 24  
2 hours of the decision. Except for concurrent review  
3 decisions pertaining to care that is underway, which shall  
4 be communicated to the enrollee's treating provider  
5 within 24 hours, decisions resulting in denial, delay, or  
6 modification of all or part of the requested health care  
7 service shall be communicated to the enrollee in writing  
8 within two business days of the decision. In the case of  
9 concurrent review, care shall not be discontinued until  
10 the enrollee's treating provider has been notified of the  
11 plan's decision, and a care plan has been agreed upon by  
12 the treating provider that is appropriate for the medical  
13 needs of that patient.

14 (4) Communications regarding decisions to approve  
15 requests by providers prior to, retrospectively, or  
16 concurrent with the provision of health care services to  
17 enrollees shall specify the specific health care service  
18 approved. Responses regarding decisions to deny, delay,  
19 or modify health care services requested by providers  
20 prior to, retrospectively, or concurrent with the provision  
21 of health care services to enrollees shall be  
22 communicated to the enrollee in writing, and to  
23 providers initially by telephone or facsimile, except with  
24 regard to decisions rendered retrospectively, and then in  
25 writing, and shall include a clear and concise explanation  
26 of the reasons for the plan's decision, a description of the  
27 criteria or guidelines used, and the clinical reasons for the  
28 decisions regarding medical necessity. Any written  
29 communication to a physician or other health care  
30 provider of a denial, delay, or modification of a request  
31 shall include the name and telephone number of the  
32 health care professional responsible for the denial, delay,  
33 or modification. The telephone number provided shall be  
34 a direct number or an extension, to allow the physician or  
35 health care provider easily to contact the professional  
36 responsible for the denial, delay, or modification.  
37 Responses shall also include information as to how the  
38 enrollee may file a grievance with the plan pursuant to  
39 Section 1368, and in the case of Medi-Cal enrollees, shall  
40 explain how to request an administrative hearing and aid

1 paid pending under Sections 51014.1 and 51014.2 of Title  
2 22 of the California Code of Regulations.

3 (5) If the health care service plan cannot make a  
4 decision to approve, modify, or deny the request for  
5 authorization within the timeframes specified in  
6 paragraph (1) or (2) because the plan is not in receipt of  
7 all of the information reasonably necessary and  
8 requested, or because the plan requires consultation by  
9 an expert reviewer, or because the plan has asked that an  
10 additional examination or test be performed upon the  
11 enrollee, provided the examination or test is reasonable  
12 and consistent with good medical practice, the plan shall,  
13 immediately upon the expiration of the timeframe  
14 specified in paragraph (1) or (2) or as soon as the plan  
15 becomes aware that it will not meet the timeframe,  
16 whichever occurs first, notify the provider and the  
17 enrollee, in writing, that the plan cannot make a decision  
18 to approve, modify, or deny the request for authorization  
19 within the required timeframe, and specify the  
20 information requested but not received, or the expert  
21 reviewer to be consulted, or the additional examinations  
22 or tests required. The plan shall also notify the provider  
23 and enrollee of the anticipated date on which a decision  
24 may be rendered. Upon receipt of all information  
25 reasonably necessary and requested by the plan, the plan  
26 shall approve, modify, or deny the request for  
27 authorization within the timeframes specified in  
28 paragraph (1) or (2), whichever applies.

29 (6) If the director determines that a health care  
30 service plan has failed to meet any of the timeframes in  
31 this section, or has failed to meet any other requirement  
32 of this section, the director may assess, by order,  
33 administrative penalties for each failure. A proceeding  
34 for the issuance of an order assessing administrative  
35 penalties shall be subject to appropriate notice to, and an  
36 opportunity for a hearing with regard to, the person  
37 affected, in accordance with subdivision (a) of Section  
38 1397. The administrative penalties shall not be deemed an  
39 exclusive remedy for the director. These penalties shall  
40 be paid to the State Managed Care Fund.

(i) Every health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) Every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(l) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 9. Section 1367.5 of the Health and Safety Code is repealed.

SEC. 10. Section 1367.51 of the Health and Safety Code is amended to read:

1367.51. (a) Every health care service plan contract, except a specialized health care service plan contract,



1 that is issued, amended, delivered, or renewed on or after  
2 January 1, 2000, and that covers hospital, medical, or  
3 surgical expenses shall include coverage for the following  
4 equipment and supplies for the management and  
5 treatment of insulin-using diabetes, non-insulin-using  
6 diabetes, and gestational diabetes as medically necessary,  
7 even if the items are available without a prescription:

8 (1) Blood glucose monitors and blood glucose testing  
9 strips.

10 (2) Blood glucose monitors designed to assist the  
11 visually impaired.

12 (3) Insulin pumps and all related necessary supplies.

13 (4) Ketone urine testing strips.

14 (5) Lancets and lancet puncture devices.

15 (6) Pen delivery systems for the administration of  
16 insulin.

17 (7) Podiatric devices to prevent or treat  
18 diabetes-related complications.

19 (8) Insulin syringes.

20 (9) Visual aids, excluding eyewear, to assist the visually  
21 impaired with proper dosing of insulin.

22 (b) Every health care service plan contract, except a  
23 specialized health care service plan contract, that is  
24 issued, amended, delivered, or renewed on or after  
25 January 1, 2000, that covers prescription benefits shall  
26 include coverage for the following prescription items if  
27 the items are determined to be medically necessary:

28 (1) Insulin.

29 (2) Prescriptive medications for the treatment of  
30 diabetes.

31 (3) Glucagon.

32 (c) The copayments and deductibles for the benefits  
33 specified in subdivisions (a) and (b) shall not exceed  
34 those established for similar benefits within the given  
35 plan.

36 (d) Every plan shall provide coverage for diabetes  
37 outpatient self-management training, education, and  
38 medical nutrition therapy necessary to enable an enrollee  
39 to properly use the equipment, supplies, and medications  
40 set forth in subdivisions (a) and (b), and additional



1 diabetes outpatient self-management training,  
2 education, and medical nutrition therapy upon the  
3 direction or prescription of those services by the  
4 enrollee's participating physician. If a plan delegates  
5 outpatient self-management training to contracting  
6 providers, the plan shall require contracting providers to  
7 ensure that diabetes outpatient self-management  
8 training, education, and medical nutrition therapy are  
9 provided by appropriately licensed or registered health  
10 care professionals.

11 (e) The diabetes outpatient self-management  
12 training, education, and medical nutrition therapy  
13 services identified in subdivision (d) shall be provided by  
14 appropriately licensed or registered health care  
15 professionals as prescribed by a participating health care  
16 professional legally authorized to prescribe the service.  
17 These benefits shall include, but not be limited to,  
18 instruction that will enable diabetic patients and their  
19 families to gain an understanding of the diabetic disease  
20 process, and the daily management of diabetic therapy,  
21 in order to thereby avoid frequent hospitalizations and  
22 complications.

23 (f) The copayments for the benefits specified in  
24 subdivision (d) shall not exceed those established for  
25 physician office visits by the plan.

26 (g) Every health care service plan governed by this  
27 section shall disclose the benefits covered pursuant to this  
28 section in the plan's evidence of coverage and disclosure  
29 forms.

30 (h) A health care service plan may not reduce or  
31 eliminate coverage as a result of the requirements of this  
32 section.

33 SEC. 11. Section 1368 of the Health and Safety Code  
34 is amended to read:

35 1368. (a) Every plan shall do all of the following:

36 (1) Establish and maintain a grievance system  
37 approved by the department under which enrollees may  
38 submit their grievances to the plan. Each system shall  
39 provide reasonable procedures in accordance with  
40 department regulations that shall ensure adequate

1 consideration of enrollee grievances and rectification  
2 when appropriate.

3 (2) Inform its subscribers and enrollees upon  
4 enrollment in the plan and annually thereafter of the  
5 procedure for processing and resolving grievances. The  
6 information shall include the location and telephone  
7 number where grievances may be submitted.

8 (3) Provide forms for grievances to be given to  
9 subscribers and enrollees who wish to register written  
10 grievances. The forms used by plans licensed pursuant to  
11 Section 1353 shall be approved by the director in advance  
12 as to format.

13 (4) Provide subscribers and enrollees with written  
14 responses to grievances, with a clear and concise  
15 explanation of the reasons for the plan's response. For  
16 grievances involving the delay, denial, or modification of  
17 health care services, the plan response shall describe the  
18 criteria used and the clinical reasons for its decision,  
19 including all criteria and clinical reasons related to  
20 medical necessity. If a plan, or one of its contracting  
21 providers, issues a decision delaying, denying, or  
22 modifying health care services based in whole or in part  
23 on a finding that the proposed health care services are not  
24 a covered benefit under the contract that applies to the  
25 enrollee, the decision shall clearly specify the provisions  
26 in the contract that exclude that coverage.

27 (5) Keep in its files all copies of grievances, and the  
28 responses thereto, for a period of five years.

29 (b) (1) (A) After either completing the grievance  
30 process described in subdivision (a), or participating in  
31 the process for at least 30 days, a subscriber or enrollee  
32 may submit the grievance to the department for review.  
33 In any case determined by the department to be a case  
34 involving an imminent and serious threat to the health of  
35 the patient, including, but not limited to, severe pain, the  
36 potential loss of life, limb, or major bodily function, or in  
37 any other case where the department determines that an  
38 earlier review is warranted, a subscriber or enrollee shall  
39 not be required to complete the grievance process or



1 participate in the process for at least 30 days before  
2 submitting a grievance to the department for review.

3 (B) A grievance may be submitted to the department  
4 for review and resolution prior to any arbitration.

5 (C) Notwithstanding subparagraphs (A) and (B), the  
6 department may refer any grievance that does not  
7 pertain to compliance with this chapter to the State  
8 Department of Health Services, the California  
9 Department of Aging, the federal Health Care Financing  
10 Administration, or any other appropriate governmental  
11 entity for investigation and resolution.

12 (2) If the subscriber or enrollee is a minor, or is  
13 incompetent or incapacitated, the parent, guardian,  
14 conservator, relative, or other designee of the subscriber  
15 or enrollee, as appropriate, may submit the grievance to  
16 the department as the agent of the subscriber or enrollee.  
17 Further, a provider may join with, or otherwise assist, a  
18 subscriber or enrollee, or the agent, to submit the  
19 grievance to the department. In addition, following  
20 submission of the grievance to the department, the  
21 subscriber or enrollee, or the agent, may authorize the  
22 provider to assist, including advocating on behalf of the  
23 subscriber or enrollee. For purposes of this section, a  
24 “relative” includes the parent, stepparent, spouse, adult  
25 son or daughter, grandparent, brother, sister, uncle, or  
26 aunt of the subscriber or enrollee.

27 (3) The department shall review the written  
28 documents submitted with the subscriber’s or the  
29 enrollee’s request for review, or submitted by the agent  
30 on behalf of the subscriber or enrollee. The department  
31 may ask for additional information, and may hold an  
32 informal meeting with the involved parties, including  
33 providers who have joined in submitting the grievance or  
34 who are otherwise assisting or advocating on behalf of the  
35 subscriber or enrollee. If after reviewing the record, the  
36 department concludes that the grievance, in whole or in  
37 part, is eligible for review under the independent  
38 medical review system established pursuant to Article  
39 5.55 (commencing with Section 1374.30), the department  
40 shall immediately notify the subscriber or enrollee, or

1 agent, of that option and shall, if requested orally or in  
2 writing, assist the subscriber or enrollee in participating  
3 in the independent medical review system.

4 (4) If after reviewing the record of a grievance, the  
5 department concludes that a health care service eligible  
6 for coverage and payment under a health care service  
7 plan contract has been delayed, denied, or modified by a  
8 plan, or by one of its contracting providers, in whole or in  
9 part due to a determination that the service is not  
10 medically necessary, and that determination was not  
11 communicated to the enrollee in writing along with a  
12 notice of the enrollee's potential right to participate in  
13 the independent medical review system, as required by  
14 this chapter, the director shall, by order, assess  
15 administrative penalties. A proceeding for the issuance of  
16 an order assessing administrative penalties shall be  
17 subject to appropriate notice of, and the opportunity for,  
18 a hearing with regard to the person affected in  
19 accordance with Section 1397. The administrative  
20 penalties shall not be deemed an exclusive remedy  
21 available to the director. These penalties shall be paid to  
22 the State Managed Care Fund.

23 (5) The department shall send a written notice of the  
24 final disposition of the grievance, and the reasons  
25 therefor, to the subscriber or enrollee, the agent, to any  
26 provider that has joined with or is otherwise assisting the  
27 subscriber or enrollee, and to the plan, within 30 calendar  
28 days of receipt of the request for review unless the  
29 director, in his or her discretion, determines that  
30 additional time is reasonably necessary to fully and fairly  
31 evaluate the relevant grievance. In any case not eligible  
32 for the independent medical review system established  
33 pursuant to Article 5.55 (commencing with Section  
34 1374.30), the department's written notice shall include, at  
35 a minimum, the following:

36 (A) A summary of its findings and the reasons why the  
37 department found the plan to be, or not to be, in  
38 compliance with any applicable laws, regulations, or  
39 orders of the director.

1 (B) A discussion of the department's contact with any  
2 medical provider, or any other independent expert relied  
3 on by the department, along with a summary of the views  
4 and qualifications of that provider or expert.

5 (C) If the enrollee's grievance is sustained in whole or  
6 part, information about any corrective action taken.

7 (6) In any department review of a grievance involving  
8 a disputed health care service, as defined in subdivision  
9 (b) of Section 1374.30, that is not eligible for the  
10 independent medical review system established  
11 pursuant to Article 5.55 (commencing with Section  
12 1374.30), in which the department finds that the plan has  
13 delayed, denied, or modified health care services that are  
14 medically necessary, based on the specific medical  
15 circumstances of the enrollee, and those services are a  
16 covered benefit under the terms and conditions of the  
17 health care service plan contract, the department's  
18 written notice shall either: (A) order the plan to  
19 promptly offer and provide those health care services to  
20 the enrollee, or (B) order the plan to promptly reimburse  
21 the enrollee for any reasonable costs associated with  
22 urgent care or emergency services, or other  
23 extraordinary and compelling health care services, when  
24 the department finds that the enrollee's decision to  
25 secure those services outside of the plan network was  
26 reasonable under the circumstances. The department's  
27 order shall be binding on the plan.

28 (7) Distribution of the written notice shall not be  
29 deemed a waiver of any exemption or privilege under  
30 existing law, including, but not limited to, Section 6254.5  
31 of the Government Code, for any information in  
32 connection with and including the written notice, nor  
33 shall any person employed or in any way retained by the  
34 department be required to testify as to that information  
35 or notice.

36 (8) The director shall establish and maintain a system  
37 of aging of grievances that are pending and unresolved  
38 for 30 days or more, that shall include a brief explanation  
39 of the reasons each grievance is pending and unresolved  
40 for 30 days or more.

1 (9) A subscriber or enrollee, or the agent acting on  
2 behalf of a subscriber or enrollee, may also request  
3 voluntary mediation with the plan prior to exercising the  
4 right to submit a grievance to the department. The use of  
5 mediation services shall not preclude the right to submit  
6 a grievance to the department upon completion of  
7 mediation. In order to initiate mediation, the subscriber  
8 or enrollee, or the agent acting on behalf of the subscriber  
9 or enrollee, and the plan shall voluntarily agree to  
10 mediation. Expenses for mediation shall be borne equally  
11 by both sides. The department shall have no  
12 administrative or enforcement responsibilities in  
13 connection with the voluntary mediation process  
14 authorized by this paragraph.

15 (c) The plan's grievance system shall include a system  
16 of aging of grievances that are pending and unresolved  
17 for 30 days or more. The plan shall provide a quarterly  
18 report to the director of grievances pending and  
19 unresolved for 30 or more days with separate categories  
20 of grievances for Medicare enrollees and Medi-Cal  
21 enrollees. The plan shall include with the report a brief  
22 explanation of the reasons each grievance is pending and  
23 unresolved for 30 days or more. The plan may include the  
24 following statement in the quarterly report that is made  
25 available to the public by the director:

26  
27 "Under Medicare and Medi-Cal law, Medicare  
28 enrollees and Medi-Cal enrollees each have separate  
29 avenues of appeal that are not available to other  
30 enrollees. Therefore, grievances pending and  
31 unresolved may reflect enrollees pursuing their  
32 Medicare or Medi-Cal appeal rights."

33  
34 If requested by a plan, the director shall include this  
35 statement in a written report made available to the public  
36 and prepared by the director that describes or compares  
37 grievances that are pending and unresolved with the plan  
38 for 30 days or more. Additionally, the director shall, if  
39 requested by a plan, append to that written report a brief  
40 explanation, provided in writing by the plan, of the



1 reasons why grievances described in that written report  
2 are pending and unresolved for 30 days or more. The  
3 director shall not be required to include a statement or  
4 append a brief explanation to a written report that the  
5 director is required to prepare under this chapter,  
6 including Sections 1380 and 1397.5.

7 (d) Subject to subparagraph (C) of paragraph (1) of  
8 subdivision (b), the grievance or resolution procedures  
9 authorized by this section shall be in addition to any other  
10 procedures that may be available to any person, and  
11 failure to pursue, exhaust, or engage in the procedures  
12 described in this section shall not preclude the use of any  
13 other remedy provided by law.

14 (e) Nothing in this section shall be construed to allow  
15 the submission to the department of any provider  
16 grievance under this section. However, as part of a  
17 provider's duty to advocate for medically appropriate  
18 health care for his or her patients pursuant to Sections 510  
19 and 2056 of the Business and Professions Code, nothing in  
20 this subdivision shall be construed to prohibit a provider  
21 from contacting and informing the department about any  
22 concerns he or she has regarding compliance with or  
23 enforcement of this chapter.

24 SEC. 12. Section 1368.04 of the Health and Safety  
25 Code is amended to read:

26 1368.04. (a) The director shall investigate and take  
27 enforcement action against plans regarding grievances  
28 reviewed and found by the department to involve  
29 noncompliance with the requirements of this chapter,  
30 including grievances that have been reviewed pursuant  
31 to the independent medical review system established  
32 pursuant to Article 5.55 (commencing with Section  
33 1374.30). Where substantial harm to an enrollee has  
34 occurred as a result of plan noncompliance, the director  
35 shall, by order, assess administrative penalties subject to  
36 appropriate notice of, and the opportunity for, a hearing  
37 with regard to the person affected in accordance with  
38 Section 1397. The administrative penalties shall not be  
39 deemed an exclusive remedy available to the director.  
40 These penalties shall be paid to the State Managed Care



1 Fund. The director shall periodically evaluate grievances  
2 to determine if any audit, investigative, or enforcement  
3 actions should be undertaken by the department.

4 (b) The director may, after appropriate notice and  
5 opportunity for hearing in accordance with Section 1397,  
6 by order, assess administrative penalties if the director  
7 determines that a health care service plan has knowingly  
8 committed, or has performed with a frequency that  
9 indicates a general business practice, either of the  
10 following:

11 (1) Repeated failure to act promptly and reasonably to  
12 investigate and resolve grievances in accordance with  
13 Section 1368.01.

14 (2) Repeated failure to act promptly and reasonably to  
15 resolve grievances when the obligation of the plan to the  
16 enrollee or subscriber is reasonably clear.

17 (c) The administrative penalties available to the  
18 director pursuant to this section are not exclusive, and  
19 may be sought and employed in any combination with  
20 civil, criminal, and other administrative remedies  
21 deemed warranted by the director to enforce this  
22 chapter.

23 (d) The administrative penalties authorized pursuant  
24 to this section shall be paid to the State Managed Care  
25 Fund.

26 SEC. 13. Section 1370.4 of the Health and Safety Code  
27 is amended to read:

28 1370.4. (a) Every health care service plan shall  
29 provide an external, independent review process to  
30 examine the plan's coverage decisions regarding  
31 experimental or investigational therapies for individual  
32 enrollees who meet all of the following criteria:

33 (1) (A) The enrollee has a life-threatening or  
34 seriously debilitating condition.

35 (B) For purposes of this section, "life-threatening"  
36 means either or both of the following:

37 (i) Diseases or conditions where the likelihood of  
38 death is high unless the course of the disease is  
39 interrupted.



1 (ii) Diseases or conditions with potentially fatal  
2 outcomes, where the end point of clinical intervention is  
3 survival.

4 (C) For purposes of this section, “seriously  
5 debilitating” means diseases or conditions that cause  
6 major irreversible morbidity.

7 (2) The enrollee’s physician certifies that the enrollee  
8 has a condition, as defined in paragraph (1), for which  
9 standard therapies have not been effective in improving  
10 the condition of the enrollee, for which standard  
11 therapies would not be medically appropriate for the  
12 enrollee, or for which there is no more beneficial standard  
13 therapy covered by the plan than the therapy proposed  
14 pursuant to paragraph (3).

15 (3) Either (A) the enrollee’s physician, who is under  
16 contract with or employed by the plan, has  
17 recommended a drug, device, procedure or other  
18 therapy that the physician certifies in writing is likely to  
19 be more beneficial to the enrollee than any available  
20 standard therapies, or (B) the enrollee, or the enrollee’s  
21 physician who is a licensed, board-certified or  
22 board-eligible physician qualified to practice in the area  
23 of practice appropriate to treat the enrollee’s condition,  
24 has requested a therapy that, based on two documents  
25 from the medical and scientific evidence, as defined in  
26 subdivision (d), is likely to be more beneficial for the  
27 enrollee than any available standard therapy. The  
28 physician certification pursuant to this subdivision shall  
29 include a statement of the evidence relied upon by the  
30 physician in certifying his or her recommendation.  
31 Nothing in this subdivision shall be construed to require  
32 the plan to pay for the services of a nonparticipating  
33 physician provided pursuant to this subdivision, that are  
34 not otherwise covered pursuant to the plan contract.

35 (4) The enrollee has been denied coverage by the plan  
36 for a drug, device, procedure, or other therapy  
37 recommended or requested pursuant to paragraph (3).

38 (5) The specific drug, device, procedure, or other  
39 therapy recommended pursuant to paragraph (3) would

1 be a covered service, except for the plan's determination  
2 that the therapy is experimental or investigational.

3 (b) The plan's decision to delay, deny, or modify  
4 experimental or investigational therapies shall be subject  
5 to the independent medical review process under Article  
6 5.55 (commencing with Section 1374.30) except that, in  
7 lieu of the information specified in subdivision (b) of  
8 Section 1374.33, an independent medical reviewer shall  
9 base his or her determination on relevant medical and  
10 scientific evidence, including, but not limited to, the  
11 medical and scientific evidence defined in subdivision  
12 (d).

13 (c) The independent medical review process shall also  
14 meet the following criteria:

15 (1) The plan shall notify eligible enrollees in writing of  
16 the opportunity to request the external independent  
17 review within five business days of the decision to deny  
18 coverage.

19 (2) If the enrollee's physician determines that the  
20 proposed therapy would be significantly less effective if  
21 not promptly initiated, the analyses and  
22 recommendations of the experts on the panel shall be  
23 rendered within seven days of the request for expedited  
24 review. At the request of the expert, the deadline shall be  
25 extended by up to three days for a delay in providing the  
26 documents required. The timeframes specified in this  
27 paragraph shall be in addition to any otherwise applicable  
28 timeframes contained in subdivision (c) of Section  
29 1374.33.

30 (3) Each expert's analysis and recommendation shall  
31 be in written form and state the reasons the requested  
32 therapy is or is not likely to be more beneficial for the  
33 enrollee than any available standard therapy, and the  
34 reasons that the expert recommends that the therapy  
35 should or should not be provided by the plan, citing the  
36 enrollee's specific medical condition, the relevant  
37 documents provided, and the relevant medical and  
38 scientific evidence, including, but not limited to, the  
39 medical and scientific evidence as defined in subdivision  
40 (d), to support the expert's recommendation.

1 (4) Coverage for the services required under this  
2 section shall be provided subject to the terms and  
3 conditions generally applicable to other benefits under  
4 the plan contract.

5 (d) For the purposes of subdivision (b), “medical and  
6 scientific evidence” means the following sources:

7 (1) Peer-reviewed scientific studies published in or  
8 accepted for publication by medical journals that meet  
9 nationally recognized requirements for scientific  
10 manuscripts and that submit most of their published  
11 articles for review by experts who are not part of the  
12 editorial staff.

13 (2) Peer-reviewed literature, biomedical compendia,  
14 and other medical literature that meet the criteria of the  
15 National Institutes of Health’s National Library of  
16 Medicine for indexing in Index Medicus, Excerpta  
17 Medicus (EMBASE), Medline, and MEDLARS data base  
18 Health Services Technology Assessment Research  
19 (HSTAR).

20 (3) Medical journals recognized by the Secretary of  
21 Health and Human Services, under Section 1861(t)(2) of  
22 the Social Security Act.

23 (4) The following standard reference compendia: The  
24 American Hospital Formulary Service-Drug  
25 Information, the American Medical Association Drug  
26 Evaluation, the American Dental Association Accepted  
27 Dental Therapeutics, and the United States  
28 Pharmacopoeia-Drug Information.

29 (5) Findings, studies, or research conducted by or  
30 under the auspices of federal government agencies and  
31 nationally recognized federal research institutes,  
32 including the Federal Agency for Health Care Policy and  
33 Research, National Institutes of Health, National Cancer  
34 Institute, National Academy of Sciences, Health Care  
35 Financing Administration, Congressional Office of  
36 Technology Assessment, and any national board  
37 recognized by the National Institutes of Health for the  
38 purpose of evaluating the medical value of health  
39 services.

1 (6) Peer-reviewed abstracts accepted for presentation  
2 at major medical association meetings.

3 (e) The independent review process established by  
4 this section shall be required on and after January 1, 2001.

5 SEC. 14. Section 1375.4 of the Health and Safety Code  
6 is amended to read:

7 1375.4. (a) Every contract between a health care  
8 service plan and a risk-bearing organization that is issued,  
9 amended, renewed, or delivered in this state on or after  
10 July 1, 2000, shall include provisions concerning the  
11 following, as to the risk-bearing organization's  
12 administrative and financial capacity, which shall be  
13 effective as of January 1, 2001:

14 (1) A requirement that the risk-bearing organization  
15 furnish financial information to the health care service  
16 plan or the plan's designated agent and meet any other  
17 financial requirements that assist the health care service  
18 plan in maintaining the financial viability of its  
19 arrangements for the provision of health care services in  
20 a manner that does not adversely affect the integrity of  
21 the contract negotiation process.

22 (2) A requirement that the health care service plan  
23 disclose information to the risk-bearing organization that  
24 enables the risk-bearing organization to be informed  
25 regarding the financial risk assumed under the contract.

26 (3) A requirement that the health care service plans  
27 provide payments of all risk arrangements, excluding  
28 capitation, within 180 days after close of the fiscal year.

29 (b) In accordance with subdivision (a) of Section 1344,  
30 the director shall adopt regulations on or before June 30,  
31 2000, to implement this section which shall, at a  
32 minimum, provide for the following:

33 (1) (A) A process for reviewing or grading  
34 risk-bearing organizations based on the following criteria:

35 (i) The risk-bearing organization meets criterion 1 if  
36 it reimburses, contests, or denies claims for health care  
37 services it has provided, arranged, or for which it is  
38 otherwise financially responsible in accordance with the  
39 timeframes and other requirements described in Section

1 1371 and in accordance with any other applicable state  
2 and federal laws and regulations.

3 (ii) The risk-bearing organization meets criterion 2 if  
4 it estimates its liability for incurred but not reported  
5 claims pursuant to a method that has not been held  
6 objectionable by the director, records the estimate at  
7 least quarterly as an accrual in its books and records, and  
8 appropriately reflects this accrual in its financial  
9 statements.

10 (iii) The risk-bearing organization meets criterion 3 if  
11 it maintains at all times a positive tangible net equity, as  
12 defined in subdivision (e) of Section 1300.76 of Title 10 of  
13 the California Code of Regulations.

14 (iv) The risk-bearing organization meets criterion 4 if  
15 it maintains at all times a positive level of working capital  
16 (excess of current assets over current liabilities).

17 (B) A risk-bearing organization may reduce its  
18 liabilities for purposes of calculating tangible net equity,  
19 pursuant to clause (iii) of subparagraph (A), and working  
20 capital, pursuant to clause (iv) of subparagraph (A), by  
21 the amount of any liabilities the payment of which is  
22 guaranteed by a sponsoring organization pursuant to a  
23 qualified guarantee. A sponsoring organization is one that  
24 has a tangible net equity of a level to be established by the  
25 director that is in excess of all amounts that it has  
26 guaranteed to any person or entity. A qualified guarantee  
27 is one that meets all of the following:

28 (i) It is approved by a board resolution of the  
29 sponsoring organization.

30 (ii) The sponsoring organization agrees to submit  
31 audited annual financial statements to the plan within 120  
32 days of the end of the sponsoring organization's fiscal  
33 year.

34 (iii) The guarantee is unconditional except for a  
35 maximum monetary limit.

36 (iv) The guarantee is not limited in duration with  
37 respect to liabilities arising during the term of the  
38 guarantee.

39 (v) The guarantee provides for six months' advance  
40 notice to the plan prior to its cancellation.

1 (2) The information required from risk-bearing  
2 organizations to assist in reviewing or grading these  
3 risk-bearing organizations, including balance sheets,  
4 claims reports, and designated annual, quarterly, or  
5 monthly financial statements prepared in accordance  
6 with generally accepted accounting principles, to be used  
7 in a manner, and to the extent necessary, provided to a  
8 single external party as approved by the director to the  
9 extent that it does not adversely affect the integrity of the  
10 contract negotiation process between the health care  
11 service plan and the risk-bearing organizations.

12 (3) Audits to be conducted in accordance with  
13 generally accepted auditing standards and in a manner  
14 that avoids duplication of review of the risk-bearing  
15 organization.

16 (4) A process for corrective action plans, as mutually  
17 agreed upon by the health care service plan and the  
18 risk-bearing organization and as approved by the  
19 director, for cases where the review or grading indicates  
20 deficiencies that need to be corrected by the risk-bearing  
21 organization, and contingency plans to ensure the  
22 delivery of health care services if the corrective action  
23 fails. The corrective action plan shall be approved by the  
24 director and standardized, to the extent possible, to meet  
25 the needs of the director and all health care service plans  
26 contracting with the risk-bearing organization. If the  
27 health care service plan and the risk-bearing organization  
28 are unable to determine a mutually agreeable corrective  
29 action plan, the director shall determine the corrective  
30 action plan.

31 (5) The disclosure of information by health care  
32 service plans to the risk-bearing organization that enables  
33 the risk-bearing organization to be informed regarding  
34 the risk assumed under the contract, including:

35 (A) Enrollee information monthly.

36 (B) Risk arrangement information, information  
37 pertaining to any pharmacy risk assumed under the  
38 contract, information regarding incentive payments, and  
39 information on income and expenses assigned to the  
40 risk-bearing organization quarterly.



1 (6) Periodic reports from each health care service plan  
2 to the director that include information concerning the  
3 risk-bearing organizations and the type and amount of  
4 financial risk assumed by them, and, if deemed necessary  
5 and appropriate by the director, a registration process for  
6 the risk-bearing organizations.

7 (7) The confidentiality of financial and other records  
8 to be produced, disclosed, or otherwise made available,  
9 unless as otherwise determined by the director.

10 (c) The failure by a health care service plan to comply  
11 with the contractual requirements pursuant to this  
12 section shall constitute grounds for disciplinary action.  
13 The director shall, as appropriate, within 60 days after  
14 receipt of documented violation from a risk-bearing  
15 organization, investigate and take enforcement action  
16 against a health care service plan that fails to comply with  
17 these requirements and shall periodically evaluate  
18 contracts between health care service plans and  
19 risk-bearing organizations to determine if any audit,  
20 evaluation, or enforcement actions should be undertaken  
21 by the department.

22 (d) The Financial Solvency Standards Board  
23 established in Section 1347.15 shall study and report to the  
24 director on or before January 1, 2001, regarding all of the  
25 following:

26 (1) The feasibility of requiring that there be in force  
27 insurance coverage commensurate with the financial risk  
28 assumed by the risk-bearing organization to protect  
29 against financial losses.

30 (2) The appropriateness of different risk-bearing  
31 arrangements between health care service plans and  
32 risk-bearing organizations.

33 (3) The appropriateness of the four criteria specified  
34 in paragraph (1) of subdivision (b).

35 (e) This section shall not apply to specialized health  
36 care service plans.

37 (f) For purposes of this section, “provider  
38 organization” means a medical group, independent  
39 practice association, or other entity that delivers,

1 furnishes, or otherwise arranges for or provides health  
2 care services, but does not include an individual or a plan.

3 (g) (1) For the purposes of this section, a  
4 “risk-bearing organization” means a professional medical  
5 corporation, other form of corporation controlled by  
6 physicians and surgeons, a medical partnership, a medical  
7 foundation exempt from licensure pursuant to  
8 subdivision (l) of Section 1206, or another lawfully  
9 organized group of physicians that delivers, furnishes, or  
10 otherwise arranges for or provides health care services,  
11 but does not include an individual or a health care service  
12 plan, and that does all of the following:

13 (A) Contracts directly with a health care service plan  
14 or arranges for health care services for the health care  
15 service plan’s enrollees.

16 (B) Receives compensation for those services on any  
17 capitated or fixed periodic payment basis.

18 (C) Is responsible for the processing and payment of  
19 claims made by providers for services rendered by those  
20 providers on behalf of a health care service plan that are  
21 covered under the capitation or fixed periodic payment  
22 made by the plan to the risk-bearing organization.  
23 Nothing in this subparagraph in any way limits, alters, or  
24 abrogates any responsibility of a health care service plan  
25 under existing law.

26 (2) Notwithstanding paragraph (1), risk-bearing  
27 organizations shall not be deemed to include a provider  
28 organization that meets either of the following  
29 requirements:

30 (A) The health care service plan files with the  
31 department consolidated financial statements that  
32 include the provider organization.

33 (B) The health care service plan is the only health care  
34 service plan with which the provider organization  
35 contracts for arranging or providing health care services  
36 and, during the previous and current fiscal years, the  
37 provider organization’s maximum potential expenses for  
38 providing or arranging for health care services did not  
39 exceed 115 percent of its maximum potential revenue for  
40 providing or arranging for those services.

(h) For purposes of this section, “claims” include, but are not limited to, contractual obligations to pay capitation or payments on a managed hospital payment basis.

SEC. 15. Section 1386 of the Health and Safety Code is amended to read:

1386. (a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

(2) The plan has issued, or permits others to use, evidence of coverage or uses a schedule of charges for health care services which do not comply with those published in the latest evidence of coverage found unobjectionable by the director.

(3) The plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage. This subdivision shall not apply to specialized health care service plan contracts.

(4) The plan is no longer able to meet the standards set forth in Article 5 (commencing with Section 1367).

(5) The continued operation of the plan will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted

1 by the director pursuant to this chapter, or any order  
2 issued by the director pursuant to this chapter.

3 (7) The plan has engaged in any conduct that  
4 constitutes fraud or dishonest dealing or unfair  
5 competition, as defined by Section 17200 of the Business  
6 and Professions Code.

7 (8) The plan has permitted, or aided or abetted any  
8 violation by an employee or contractor who is a holder of  
9 any certificate, license, permit, registration or exemption  
10 issued pursuant to the Business and Professions Code, or  
11 this code which would constitute grounds for discipline  
12 against the certificate, license, permit, registration, or  
13 exemption.

14 (9) The plan has aided or abetted or permitted the  
15 commission of any illegal act.

16 (10) The engagement of a person as an officer,  
17 director, employee, associate, or provider of the plan  
18 contrary to the provisions of an order issued by the  
19 director pursuant to subdivision (c) of this section or  
20 subdivision (d) of Section 1388.

21 (11) The engagement of a person as a solicitor or  
22 supervisor of solicitation contrary to the provisions of an  
23 order issued by the director pursuant to Section 1388.

24 (12) The plan, its management company, or any other  
25 affiliate of the plan, or any controlling person, officer,  
26 director, or other person occupying a principal  
27 management or supervisory position in the plan,  
28 management company or affiliate, has been convicted of  
29 or pleaded nolo contendere to a crime, or committed any  
30 act involving dishonesty, fraud, or deceit, which crime or  
31 act is substantially related to the qualifications, functions,  
32 or duties of a person engaged in business in accordance  
33 with this chapter. The director may revoke or deny a  
34 license hereunder irrespective of a subsequent order  
35 under the provisions of Section 1203.4 of the Penal Code.

36 (13) The plan violates Section 510, 2056, or 2056.1 of  
37 the Business and Professions Code.

38 (14) The plan has been subject to a final disciplinary  
39 action taken by this state, another state, an agency of the

1 federal government, or another country, for any act or  
2 omission that would constitute a violation of this chapter.

3 (15) The plan violates the Confidentiality of Medical  
4 Information Act (Part 2.6 (commencing with Section 56)  
5 of Division 1 of the Civil Code).

6 (c) (1) The director may prohibit any person from  
7 serving as an officer, director, employee, associate, or  
8 provider of any plan or solicitor firm, or of any  
9 management company of any plan, or as a solicitor, if  
10 either of the following applies:

11 (A) The prohibition is in the public interest and the  
12 person has committed, caused, participated in, or had  
13 knowledge of a violation of this chapter by a plan,  
14 management company, or solicitor firm.

15 (B) The person was an officer, director, employee,  
16 associate, or provider of a plan or of a management  
17 company or solicitor firm of any plan whose license has  
18 been suspended or revoked pursuant to this section and  
19 the person had knowledge of, or participated in, any of  
20 the prohibited acts for which the license was suspended  
21 or revoked.

22 (2) A proceeding for the issuance of an order under  
23 this subdivision may be included with a proceeding  
24 against a plan under this section or may constitute a  
25 separate proceeding, subject in either case to subdivision  
26 (d).

27 (d) A proceeding under this section shall be subject to  
28 appropriate notice to, and the opportunity for a hearing  
29 with regard to, the person affected in accordance with  
30 subdivision (a) of Section 1397.

31 SEC. 16. Section 1395.6 of the Health and Safety Code  
32 is amended to read:

33 1395.6. (a) In order to prevent the improper selling,  
34 leasing, or transferring of a health care provider's  
35 contract, it is the intent of the Legislature that every  
36 arrangement that results in any payor paying a health  
37 care provider a reduced rate for health care services  
38 based on the health care provider's participation in a  
39 network or panel shall be disclosed to the provider in  
40 advance and shall actively encourage patients to use the

1 network, unless the health care provider agrees to  
2 provide discounts without that active encouragement.

3 (b) Beginning July 1, 2000, every contracting agent  
4 that sells, leases, assigns, transfers, or conveys its list of  
5 contracted health care providers and their contracted  
6 reimbursement rates to a payor or another contracting  
7 agent shall, upon entering or renewing a provider  
8 contract, do all of the following:

9 (1) Disclose to the provider whether the list of  
10 contracted providers may be sold, leased, transferred, or  
11 conveyed to other payors or other contracting agents, and  
12 specify whether those payors or contracting agents  
13 include workers' compensation insurers or automobile  
14 insurers.

15 (2) Disclose what specific practices, if any, payors  
16 utilize to actively encourage a payor's subscribers to use  
17 the list of contracted providers when obtaining medical  
18 care that entitles a payor to claim a contracted rate. For  
19 purposes of this paragraph, a payor is deemed to have  
20 actively encouraged its subscribers to use the list of  
21 contracted providers if one of the following occurs:

22 (A) The payor offers its subscribers direct financial  
23 incentives to use the list of contracted providers when  
24 obtaining medical care. "Financial incentives" means  
25 reduced copayments, reduced deductibles, premium  
26 discounts directly attributable to the use of a provider  
27 panel, or financial penalties directly attributable to the  
28 nonuse of a provider panel.

29 (B) The payor provides information to subscribers  
30 advising them of the existence of the list of contracted  
31 providers through the use of a variety of advertising or  
32 marketing approaches that supply the names, addresses,  
33 and telephone numbers of contracted providers to  
34 subscribers in advance of their selection of a health care  
35 provider, which approaches may include, but are not  
36 limited to, the use of provider directories, or the use of  
37 toll-free telephone numbers or Internet web site  
38 addresses supplied directly to every subscriber. However,  
39 Internet web site addresses alone shall not be deemed to  
40 satisfy the requirements of this subparagraph. Nothing in

1 this subparagraph shall prevent contracting agents or  
2 payors from providing only listings of providers located  
3 within a reasonable geographic range of a subscriber.

4 (3) Disclose whether payors to which the list of  
5 contracted providers may be sold, leased, transferred, or  
6 conveyed may be permitted to pay a provider's  
7 contracted rate without actively encouraging the payors'  
8 subscribers to use the list of contracted providers when  
9 obtaining medical care.

10 (4) Disclose, upon the initial signing of a contract, and  
11 within 30 calendar days of receipt of a written request  
12 from a provider or provider panel, a payor summary of all  
13 payors currently eligible to claim a provider's contracted  
14 rate due to the provider's and payor's respective written  
15 agreement with any contracting agent.

16 Nothing in this subdivision shall be construed to require  
17 a payor to actively encourage the payor's subscribers to  
18 use the list of contracted providers when obtaining  
19 medical care in the case of an emergency.

20 (c) A contracting agent shall allow providers, upon the  
21 initial signing, renewal, or amendment of a provider  
22 contract, to decline to be included in any list of contracted  
23 providers that is sold, leased, transferred, or conveyed to  
24 payors that do not actively encourage the payors'  
25 subscribers to use the list of contracted providers when  
26 obtaining medical care as described in paragraph (2) of  
27 subdivision (b). Each provider's election under this  
28 subdivision shall be binding on every contracting agent  
29 or payor that buys, leases, or otherwise obtains a list of  
30 contracted providers.

31 (d) A provider shall not be excluded from any list of  
32 contracted providers that is sold, leased, transferred, or  
33 conveyed to payors that actively encourage the payors'  
34 subscribers to use the list of contracted providers when  
35 obtaining medical care, based upon the provider's refusal  
36 to be included on any list of contracted providers that is  
37 sold, leased, transferred, or conveyed to payors that do  
38 not actively encourage the payors' subscribers to use the  
39 list of contracted providers when obtaining medical care.



1 (e) A payor shall provide an explanation of benefits or  
2 explanation of review that identifies the name of the  
3 network that has a written agreement signed by the  
4 provider whereby the payor is entitled, directly or  
5 indirectly, to pay a preferred rate for the services  
6 rendered.

7 (f) A payor shall demonstrate that it is entitled to pay  
8 a contracted rate within 30 business days of receipt of a  
9 written request from a provider who has received a claim  
10 payment from the payor. The failure of a payor to do so  
11 shall render the payor liable for the amount that the  
12 payor would have been required to pay pursuant to the  
13 applicable health care service plan contract covering the  
14 enrollee, which amount shall be due and payable within  
15 10 days of receipt of written notice from the provider, and  
16 shall bar the payor from taking any future discounts from  
17 that provider without the provider's express written  
18 consent until the payor can demonstrate to the provider  
19 that it is entitled to pay a contracted rate as provided in  
20 this subdivision. A payor shall be deemed to have  
21 demonstrated that it is entitled to pay a contracted rate  
22 if it complies with either of the following:

23 (1) Discloses the name of the network that has a  
24 written agreement with the provider whereby the  
25 provider agrees to accept discounted rates, and describes  
26 the specific practices the payor utilizes to comply with  
27 paragraph (2) of subdivision (b).

28 (2) Identifies the provider's written agreement with a  
29 contracting agent whereby the provider agrees to be  
30 included on lists of contracted providers sold, leased,  
31 transferred, or conveyed to payors that do not actively  
32 encourage beneficiaries to use the list of contracted  
33 providers pursuant to subdivision (c).

34 (g) For the purposes of this section, the following  
35 terms have the following meanings:

36 (1) "Contracting agent" means a health care service  
37 plan or a specialized health care service plan, while  
38 engaged, for monetary or other consideration, in the act  
39 of selling, leasing, transferring, assigning, conveying, or

1 arranging the availability of a provider or provider panel  
2 to provide health care services to subscribers.

3 (2) “Payor” means a health care service plan or a  
4 specialized health care service plan.

5 (3) “Payor summary” means a written summary that  
6 includes the payor’s name and the type of plan, including,  
7 but not limited to, a group health plan, an automobile  
8 insurance plan, and a workers’ compensation insurance  
9 plan.

10 (4) “Provider” means any of the following:

11 (A) Any person licensed or certified pursuant to  
12 Division 2 (commencing with Section 500) of the  
13 Business and Professions Code.

14 (B) Any person licensed pursuant to the Chiropractic  
15 Initiative Act or the Osteopathic Initiative Act.

16 (C) Any person licensed pursuant to Chapter 2.5  
17 (commencing with Section 1440) of Division 2.

18 (D) A clinic, health dispensary, or health facility  
19 licensed pursuant to Division 2 (commencing with  
20 Section 1200).

21 (E) Any entity exempt from licensure pursuant to  
22 Section 1206.

23 (h) This section shall become operative on July 1, 2000.

24 SEC. 17. Section 13933 of the Health and Safety Code  
25 is amended and renumbered to read:

26 1374.34. (a) Upon receiving the decision adopted by  
27 the director pursuant to Section 1374.33 that a disputed  
28 health care service is medically necessary, the plan shall  
29 promptly implement the decision. In the case of  
30 reimbursement for services already rendered, the plan  
31 shall reimburse the provider or enrollee, whichever  
32 applies, within five working days. In the case of services  
33 not yet rendered, the plan shall authorize the services  
34 within five working days of receipt of the written decision  
35 from the director, or sooner if appropriate for the nature  
36 of the enrollee’s medical condition, and shall inform the  
37 enrollee and provider of the authorization in accordance  
38 with the requirements of paragraph (3) of subdivision  
39 (h) of Section 1367.01.

1 (b) A plan shall not engage in any conduct that has the  
2 effect of prolonging the independent review process. The  
3 engaging in that conduct or the failure of the plan to  
4 promptly implement the decision is a violation of this  
5 chapter and, in addition to any other fines, penalties, and  
6 other remedies available to the director under this  
7 chapter, the plan shall be subject to an administrative  
8 penalty of not less than five thousand dollars (\$5,000) for  
9 each day that the decision is not implemented.  
10 Administrative penalties shall be deposited in the State  
11 Managed Care Fund.

12 (c) In any case where an enrollee secured urgent care  
13 or emergency services outside of the plan provider  
14 network, which services are later found by the  
15 independent medical review organization to have been  
16 medically necessary pursuant to Section 1374.33, the  
17 director shall require the plan to promptly reimburse the  
18 enrollee for any reasonable costs associated with those  
19 services when the director finds that the enrollee's  
20 decision to secure the services outside of the plan  
21 provider network prior to completing the plan grievance  
22 process or seeking an independent medical review was  
23 reasonable under the circumstances and the disputed  
24 health care services were a covered benefit under the  
25 terms and conditions of the health care service plan  
26 contract.

27 (d) In addition to requiring plan compliance  
28 regarding subdivisions (a), (b), and (c) the director shall  
29 review individual cases submitted for independent  
30 medical review to determine whether any enforcement  
31 actions, including penalties, may be appropriate. In  
32 particular, where substantial harm, as defined in Section  
33 3428 of the Civil Code, to an enrollee has already occurred  
34 because of the decision of a plan, or one of its contracting  
35 providers, to delay, deny, or modify covered health care  
36 services that an independent medical review determines  
37 to be medically necessary pursuant to Section 1374.33, the  
38 director shall impose penalties.

39 (e) Pursuant to Section 1368.04, the director shall  
40 perform an annual audit of independent medical review

1 cases for the dual purposes of education and the  
2 opportunity to determine if any investigative or  
3 enforcement actions should be undertaken by the  
4 department, particularly if a plan repeatedly fails to act  
5 promptly and reasonably to resolve grievances associated  
6 with a delay, denial, or modification of medically  
7 necessary health care services when the obligation of the  
8 plan to provide those health care services to enrollees or  
9 subscribers is reasonably clear.

10 SEC. 18. Section 10123.135 of the Insurance Code, as  
11 amended by Chapter 539 of the Statutes of 1999, is  
12 amended to read:

13 10123.135. (a) Every disability insurer, or an entity  
14 with which it contracts for services that include  
15 utilization review or utilization management functions,  
16 that covers hospital, medical, or surgical expenses and  
17 that prospectively, retrospectively, or concurrently  
18 reviews and approves, modifies, delays, or denies, based  
19 in whole or in part on medical necessity, requests by  
20 providers prior to, retrospectively, or concurrent with  
21 the provision of health care services to insureds, or that  
22 delegates these functions to medical groups or  
23 independent practice associations or to other contracting  
24 providers, shall comply with this section.

25 (b) A disability insurer that is subject to this section, or  
26 any entity with which an insurer contracts for services  
27 that include utilization review or utilization management  
28 functions, shall have written policies and procedures  
29 establishing the process by which the insurer  
30 prospectively, retrospectively, or concurrently reviews  
31 and approves, modifies, delays, or denies, based in whole  
32 or in part on medical necessity, requests by providers of  
33 health care services for insureds. These policies and  
34 procedures shall ensure that decisions based on the  
35 medical necessity of proposed health care services are  
36 consistent with criteria or guidelines that are supported  
37 by clinical principles and processes. These criteria and  
38 guidelines shall be developed pursuant to subdivision (f).  
39 These policies and procedures, and a description of the  
40 process by which an insurer, or an entity with which an



1 insurer contracts for services that include utilization  
2 review or utilization management functions, reviews and  
3 approves, modifies, delays, or denies requests by  
4 providers prior to, retrospectively, or concurrent with  
5 the provision of health care services to insureds, shall be  
6 filed with the commissioner, and shall be disclosed by the  
7 insurer to insureds and providers upon request, and by  
8 the insurer to the public upon request.

9 (c) If the number of insureds covered under health  
10 benefit plans in this state that are issued by an insurer  
11 subject to this section constitute at least 50 percent of the  
12 number of insureds covered under health benefit plans  
13 issued nationwide by that insurer, the insurer shall  
14 employ or designate a medical director who holds an  
15 unrestricted license to practice medicine in this state  
16 issued pursuant to Section 2050 of the Business and  
17 Professions Code or the Osteopathic Act, or the insurer  
18 may employ a clinical director licensed in California  
19 whose scope of practice under California law includes the  
20 right to independently perform all those services covered  
21 by the insurer. The medical director or clinical director  
22 shall ensure that the process by which the insurer reviews  
23 and approves, modifies, delays, or denies, based in whole  
24 or in part on medical necessity, requests by providers  
25 prior to, retrospectively, or concurrent with the provision  
26 of health care services to insureds, complies with the  
27 requirements of this section. Nothing in this subdivision  
28 shall be construed as restricting the existing authority of  
29 the Medical Board of California.

30 (d) If an insurer subject to this section, or individuals  
31 under contract to the insurer to review requests by  
32 providers, approve the provider's request pursuant to  
33 subdivision (b), the decision shall be communicated to  
34 the provider pursuant to subdivision (h).

35 (e) No individual, other than a licensed physician or a  
36 licensed health care professional who is competent to  
37 evaluate the specific clinical issues involved in the health  
38 care services requested by the provider, may deny or  
39 modify requests for authorization of health care services  
40 for an insured for reasons of medical necessity. The

1 decision of the physician or other health care provider  
2 shall be communicated to the provider and the insured  
3 pursuant to subdivision (h).

4 (f) (1) An insurer shall disclose, or provide for the  
5 disclosure, to the commissioner and to network providers,  
6 the process the insurer, its contracting provider groups,  
7 or any entity with which it contracts for services that  
8 include utilization review or utilization management  
9 functions, uses to authorize, delay, modify, or deny health  
10 care services under the benefits provided by the  
11 insurance contract, including coverage for subacute care,  
12 transitional inpatient care, or care provided in skilled  
13 nursing facilities. An insurer shall also disclose those  
14 processes to policyholders or persons designated by a  
15 policyholder, or to any other person or organization, upon  
16 request.

17 (2) The criteria or guidelines used by an insurer, or an  
18 entity with which an insurer contracts for utilization  
19 review or utilization management functions, to  
20 determine whether to authorize, modify, delays, or deny  
21 health care services, shall:

22 (A) Be developed with involvement from actively  
23 practicing health care providers.

24 (B) Be consistent with sound clinical principles and  
25 processes.

26 (C) Be evaluated, and updated if necessary, at least  
27 annually.

28 (D) If used as the basis of a decision to modify, delay,  
29 or deny services in a specified case under review, be  
30 disclosed to the provider and the policyholder in that  
31 specified case.

32 (E) Be available to the public upon request. An insurer  
33 shall only be required to disclose the criteria or guidelines  
34 for the specific procedures or conditions requested. An  
35 insurer may charge reasonable fees to cover  
36 administrative expenses related to disclosing criteria or  
37 guidelines pursuant to this paragraph, limited to copying  
38 and postage costs. The insurer may also make the criteria  
39 or guidelines available through electronic  
40 communication means.

1 (3) The disclosure require by subparagraph (E) of  
2 paragraph (2) shall be accompanied by the following  
3 notice: “The materials provided to you are guidelines  
4 used by this insurer to authorize, modify, or deny health  
5 care benefits for persons with similar illnesses or  
6 conditions. Specific care and treatment may vary  
7 depending on individual need and the benefits covered  
8 under your insurance contract.

9 (g) If an insurer subject to this section requests  
10 medical information from providers in order to  
11 determine whether to approve, modify, or deny requests  
12 for authorization, the insurer shall request only the  
13 information reasonably necessary to make the  
14 determination.

15 (h) In determining whether to approve, modify, or  
16 deny requests by providers prior to, retrospectively, or  
17 concurrent with the provision of health care services to  
18 insureds, based in whole or in part on medical necessity,  
19 every insurer subject to this section shall meet the  
20 following requirements:

21 (1) Decisions to approve, modify, or deny, based on  
22 medical necessity, requests by providers prior to, or  
23 concurrent with, the provision of health care services to  
24 insureds that do not meet the requirements for the  
25 72-hour review required by paragraph (2), shall be made  
26 in a timely fashion appropriate for the nature of the  
27 insured’s condition, not to exceed five business days from  
28 the insurer’s receipt of the information reasonably  
29 necessary and requested by the insurer to make the  
30 determination. In cases where the review is  
31 retrospective, the decision shall be communicated to the  
32 individual who received services, or to the individual’s  
33 designee, within 30 days of the receipt of information that  
34 is reasonably necessary to make this determination, and  
35 shall be communicated to the provider in a manner that  
36 is consistent with current law. For purposes of this  
37 section, retrospective reviews shall be for care rendered  
38 on or after January 1, 2000.

39 (2) When the insured’s condition is such that the  
40 insured faces an imminent and serious threat to his or her



1 health, including, but not limited to, the potential loss of  
2 life, limb, or other major bodily function, or the normal  
3 timeframe for the decisionmaking process, as described  
4 in paragraph (1), would be detrimental to the insured's  
5 life or health or could jeopardize the insured's ability to  
6 regain maximum function, decisions to approve, modify,  
7 or deny requests by providers prior to, or concurrent  
8 with, the provision of health care services to insureds shall  
9 be made in a timely fashion, appropriate for the nature of  
10 the insured's condition, but not to exceed 72 hours after  
11 the insurer's receipt of the information reasonably  
12 necessary and requested by the insurer to make the  
13 determination.

14 (3) Decisions to approve, modify, or deny requests by  
15 providers for authorization prior to, or concurrent with,  
16 the provision of health care services to insureds shall be  
17 communicated to the requesting provider within 24  
18 hours of the decision. Except for concurrent review  
19 decisions pertaining to care that is underway, which shall  
20 be communicated to the insured's treating provider  
21 within 24 hours, decisions resulting in denial, delay, or  
22 modification of all or part of the requested health care  
23 service shall be communicated to the insured in writing  
24 within two business days of the decision. In the case of  
25 concurrent review, care shall not be discontinued until  
26 the insured's treating provider has been notified of the  
27 insurer's decision and a care plan has been agreed upon  
28 by the treating provider that is appropriate for the  
29 medical needs of that patient.

30 (4) Communications regarding decisions to approve  
31 requests by providers prior to, retrospectively, or  
32 concurrent with the provision of health care services to  
33 insureds shall specify the specific health care service  
34 approved. Responses regarding decisions to deny, delay,  
35 or modify health care services requested by providers  
36 prior to, retrospectively, or concurrent with the provision  
37 of health care services to insureds shall be communicated  
38 to insureds in writing, and to providers initially by  
39 telephone or facsimile, except with regard to decisions  
40 rendered retrospectively, and then in writing, and shall



1 include a clear and concise explanation of the reasons for  
2 the insurer's decision, a description of the criteria or  
3 guidelines used, and the clinical reasons for the decisions  
4 regarding medical necessity. Any written  
5 communication to a physician or other health care  
6 provider of a denial, delay, or modification or a request  
7 shall include the name and telephone number of the  
8 health care professional responsible for the denial, delay,  
9 or modification. The telephone number provided shall be  
10 a direct number or an extension, to allow the physician or  
11 health care provider easily to contact the professional  
12 responsible for the denial, delay, or modification.  
13 Responses shall also include information as to how the  
14 provider or the insured may file an appeal with the  
15 insurer or seek department review under the unfair  
16 practices provisions of Article 6.5 (commencing with  
17 Section 790) of Chapter 1 of Part 7 of Division 1 and the  
18 regulations adopted thereunder.

19 (5) If the insurer cannot make a decision to approve,  
20 modify, or deny the request for authorization within the  
21 timeframes specified in paragraph (1) or (2) because the  
22 insurer is not in receipt of all of the information  
23 reasonably necessary and requested, or because the  
24 insurer requires consultation by an expert reviewer, or  
25 because the insurer has asked that an additional  
26 examination or test be performed upon the insured,  
27 provided that the examination or test is reasonable and  
28 consistent with good medical practice, the insurer shall,  
29 immediately upon the expiration of the timeframe  
30 specified in paragraph (1) or (2), or as soon as the insurer  
31 becomes aware that it will not meet the timeframe,  
32 whichever occurs first, notify the provider and the  
33 insured, in writing, that the insurer cannot make a  
34 decision to approve, modify, or deny the request for  
35 authorization within the required timeframe, and specify  
36 the information requested but not received, or the expert  
37 reviewer to be consulted, or the additional examinations  
38 or tests required. The insurer shall also notify the provider  
39 and enrollee of the anticipated date on which a decision  
40 may be rendered. Upon receipt of all information



1 reasonably necessary and requested by the insurer, the  
2 insurer shall approve, modify, or deny the request for  
3 authorization within the timeframes specified in  
4 paragraph (1) or (2), whichever applies.

5 (6) If the commissioner determines that an insurer has  
6 failed to meet any of the timeframes in this section, or has  
7 failed to meet any other requirement of this section, the  
8 commissioner may assess, by order, administrative  
9 penalties for each failure. A proceeding for the issuance  
10 of an order assessing administrative penalties shall be  
11 subject to appropriate notice to, and an opportunity for  
12 a hearing with regard to, the person affected. The  
13 administrative penalties shall not be deemed an exclusive  
14 remedy for the commissioner. These penalties shall be  
15 paid to the Insurance Fund.

16 (i) Every insurer subject to this section shall maintain  
17 telephone access for providers to request authorization  
18 for health care services.

19 (j) Nothing in this section shall cause a disability  
20 insurer to be defined as a health care provider for  
21 purposes of any provision of law, including, but not  
22 limited to, Section 6146 of the Business and Professions  
23 Code, Sections 3333.1 and 3333.2 of the Civil Code, and  
24 Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of  
25 Civil Procedure.

26 SEC. 19. Section 10145.3 of the Insurance Code is  
27 amended to read:

28 10145.3. (a) Every disability insurer that covers  
29 hospital, medical, or surgical benefits shall provide an  
30 external, independent review process to examine the  
31 insurer's coverage decisions regarding experimental or  
32 investigational therapies for individual insureds who  
33 meet all of the following criteria:

34 (1) (A) The insured has a life-threatening or seriously  
35 debilitating condition.

36 (B) For purposes of this section, "life-threatening"  
37 means either or both of the following:

38 (i) Diseases or conditions where the likelihood of  
39 death is high unless the course of the disease is  
40 interrupted.

1 (ii) Diseases or conditions with potentially fatal  
2 outcomes, where the end point of clinical intervention is  
3 survival.

4 (C) For purposes of this section, “seriously  
5 debilitating” means diseases or conditions that cause  
6 major irreversible morbidity.

7 (2) The insured’s physician certifies that the insured  
8 has a condition, as defined in paragraph (1), for which  
9 standard therapies have not been effective in improving  
10 the condition of the insured, for which standard therapies  
11 would not be medically appropriate for the insured, or for  
12 which there is no more beneficial standard therapy  
13 covered by the insurer than the therapy proposed  
14 pursuant to paragraph (3).

15 (3) Either (A) the insured’s contracting physician has  
16 recommended a drug, device, procedure, or other  
17 therapy that the physician certifies in writing is likely to  
18 be more beneficial to the insured than any available  
19 standard therapies, or (B) the insured, or the insured’s  
20 physician who is a licensed, board-certified or  
21 board-eligible physician qualified to practice in the area  
22 of practice appropriate to treat the insured’s condition,  
23 has requested a therapy that, based on two documents  
24 from the medical and scientific evidence, as defined in  
25 subdivision (d), is likely to be more beneficial for the  
26 insured than any available standard therapy. The  
27 physician certification pursuant to this subdivision shall  
28 include a statement of the evidence relied upon by the  
29 physician in certifying his or her recommendation.  
30 Nothing in this subdivision shall be construed to require  
31 the insurer to pay for the services of a noncontracting  
32 physician, provided pursuant to this subdivision, that are  
33 not otherwise covered pursuant to the contract.

34 (4) The insured has been denied coverage by the  
35 insurer for a drug, device, procedure, or other therapy  
36 recommended or requested pursuant to paragraph (3),  
37 unless coverage for the specific therapy has been  
38 excluded by the insurer’s contract.

39 (5) The specific drug, device, procedure, or other  
40 therapy recommended pursuant to paragraph (3) would

1 be a covered service except for the insurer's  
2 determination that the therapy is experimental or under  
3 investigation.

4 (b) The insurer's decision to deny, delay, or modify  
5 experimental or investigational therapies shall be subject  
6 to the independent medical review process established  
7 under Article 3.5 (commencing with Section 10169) of  
8 Chapter 1 of Part 2 of Division 2, except that in lieu of the  
9 information specified in subdivision (b) of Section  
10 10169.3, an independent medical reviewer shall base his  
11 or her determination on relevant medical and scientific  
12 evidence, including, but not limited to, the medical and  
13 scientific evidence defined in subdivision (d).

14 (c) The independent medical review process shall also  
15 meet the following criteria:

16 (1) The insurer shall notify eligible insureds in writing  
17 of the opportunity to request the external independent  
18 review within five business days of the decision to deny  
19 coverage.

20 (2) If the insured's physician determines that the  
21 proposed therapy would be significantly less effective if  
22 not promptly initiated, the analyses and  
23 recommendations of the experts on the panel shall be  
24 rendered within seven days of the request for expedited  
25 review. At the request of the expert, the deadline shall be  
26 extended by up to three days for a delay in providing the  
27 documents required. The timeframes specified in this  
28 paragraph shall be in addition to any otherwise applicable  
29 timeframes contained in subdivision (c) of Section  
30 10169.3.

31 (3) Each expert's analysis and recommendation shall  
32 be in written form and state the reasons the requested  
33 therapy is or is not likely to be more beneficial for the  
34 insured than any available standard therapy, and the  
35 reasons that the expert recommends that the therapy  
36 should or should not be covered by the insurer, citing the  
37 insured's specific medical condition, the relevant  
38 documents, and the relevant medical and scientific  
39 evidence, including, but not limited to, the medical and

1 scientific evidence as defined in subdivision (d), to  
2 support the expert's recommendation.

3 (4) Coverage for the services required under this  
4 section shall be provided subject to the terms and  
5 conditions generally applicable to other benefits under  
6 the contract.

7 (d) For the purposes of subdivision (b), "medical and  
8 scientific evidence" means the following sources:

9 (1) Peer-reviewed scientific studies published in or  
10 accepted for publication by medical journals that meet  
11 nationally recognized requirements for scientific  
12 manuscripts and that submit most of their published  
13 articles for review by experts who are not part of the  
14 editorial staff.

15 (2) Peer-reviewed literature, biomedical compendia  
16 and other medical literature that meet the criteria of the  
17 National Institutes of Health's National Library of  
18 Medicine for indexing in Index Medicus, Excerpta  
19 Medicus (EMBASE), Medline and MEDLARS data base  
20 Health Services Technology Assessment Research  
21 (HSTAR).

22 (3) Medical journals recognized by the Secretary of  
23 Health and Human Services, under Section 1861(t)(2) of  
24 the Social Security Act.

25 (4) The following standard reference compendia: The  
26 American Hospital Formulary Service-Drug  
27 Information, the American Medical Association Drug  
28 Evaluation, the American Dental Association Accepted  
29 Dental Therapeutics and The United States  
30 Pharmacopoeia-Drug Information.

31 (5) Findings, studies, or research conducted by or  
32 under the auspices of federal government agencies and  
33 nationally recognized federal research institutes,  
34 including the Federal Agency for Health Care Policy and  
35 Research, National Institutes of Health, National Cancer  
36 Institute, National Academy of Sciences, Health Care  
37 Financing Administration, Congressional Office of  
38 Technology Assessment, and any national board  
39 recognized by the National Institutes of Health for the

1 purpose of evaluating the medical value of health  
2 services.

3 (6) Peer-reviewed abstracts accepted for presentation  
4 at major medical association meetings.

5 (e) The independent review process established by  
6 this section shall be required on and after January 1, 2001.

7 SEC. 20. Section 25002 of the Welfare and Institutions  
8 Code is amended to read:

9 25002. To develop the options for achieving universal  
10 health care coverage described in Section 25001, the  
11 secretary shall establish a process by which these options  
12 are developed. The process shall at a minimum include  
13 the following:

14 (a) The examination and utilization of research results  
15 from the study performed by the University of California  
16 with regard to methods of financing, delivering and  
17 defining universal health care coverage, done pursuant to  
18 the criteria in Senate Concurrent Resolution 100 of the  
19 1997–1998 Regular Session of the Legislature.

20 (b) The examination and utilization of other data and  
21 information, as requested by the secretary or provided to  
22 the secretary, with regard to methods of financing,  
23 delivering, or defining universal health care coverage.

24 (c) Developing a process by which representatives of  
25 health care consumers, providers, insurers, health care  
26 workers, advocates, counties, and all other interested  
27 parties are engaged in discussion and debate of the issues  
28 faced by the state in providing universal health coverage.  
29 The secretary shall develop the methods by which this  
30 discussion occurs, provided that it is broadly inclusive of  
31 all groups with an interest in universal health care  
32 coverage.

33 (d) Interagency participation including, but not  
34 limited to, the State Department of Health Services, the  
35 State Department of Mental Health, the Department of  
36 Finance, the Managed Risk Medical Insurance Board, the  
37 Department of Consumer Affairs, the Public Employees'  
38 Retirement System, the State Department of Social  
39 Services, the Department of Managed Health Care, the  
40 Department of Insurance, and any other appropriate



1 agencies which the secretary determines can contribute  
2 to the effort to provide universal health care coverage.

3 (e) Obtaining information from the United States  
4 Health Care Financing Administration regarding federal  
5 waivers or other forms of federal participation, if  
6 necessary.

7 *SEC. 21. (a) Section 2.1 of this bill incorporates*  
8 *amendments to Section 56.10 of the Civil Code proposed*  
9 *by both this bill and AB 2414. It shall only become*  
10 *operative if (1) both bills are enacted and become*  
11 *effective on or before January 1, 2001, (2) each bill*  
12 *amends Section 56.10 of the Civil Code, and (3) SB 1903*  
13 *is not enacted or as enacted does not amend that section,*  
14 *and (4) this bill is enacted after AB 2414, in which case*  
15 *Sections 2, 2.2, and 2.3 of this bill shall not become*  
16 *operative.*

17 *(b) Section 2.2 of this bill incorporates amendments to*  
18 *Section 56.10 of the Civil Code proposed by both this bill*  
19 *and SB 1903. It shall only become operative if (1) both*  
20 *bills are enacted and become effective on or before*  
21 *January 1, 2001, (2) each bill amends Section 56.10 of the*  
22 *Civil Code, (3) AB 2414 is not enacted or as enacted does*  
23 *not amend that section, and (4) this bill is enacted after*  
24 *SB 1903 in which case Sections 2, 2.1, and 2.3 of this bill*  
25 *shall not become operative.*

26 *(c) Section 2.3 of this bill incorporates amendments to*  
27 *Section 56.10 of the Civil Code proposed by this bill, AB*  
28 *2414, and SB 1903. It shall only become operative if (1) all*  
29 *three bills are enacted and become effective on or before*  
30 *January 1, 2001, (2) all three bills amend Section 56.10 of*  
31 *the Civil Code, and (3) this bill is enacted after AB 2414*  
32 *and SB 1903, in which case Sections 2, 2.1, and 2.2 of this*  
33 *bill shall not become operative.*

